Choosing the Circumstances of Death.

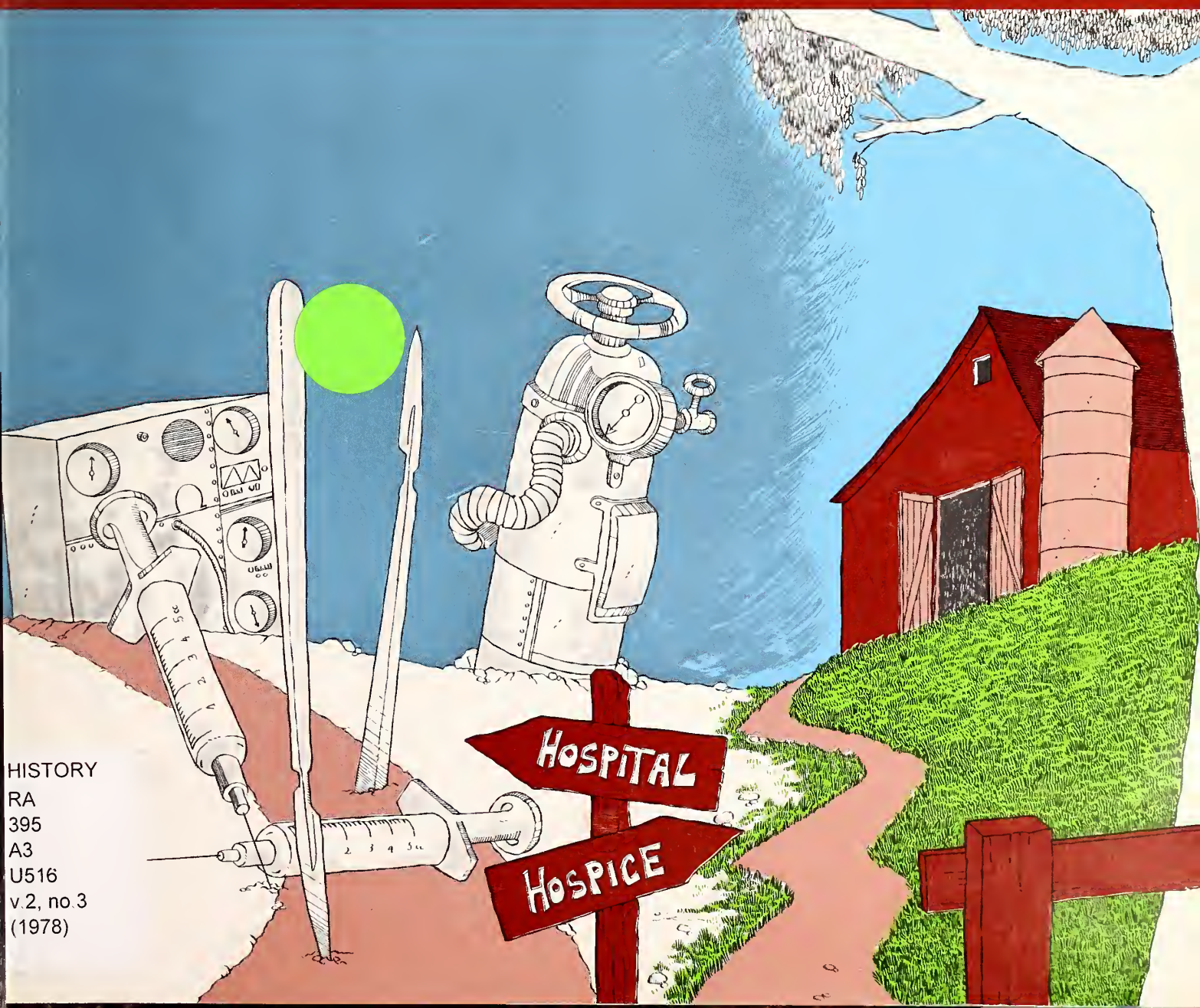
A State Hospital Commission Works To Contain Costs.

Hospitals Consolidate Services To Save $375,000 Annually.

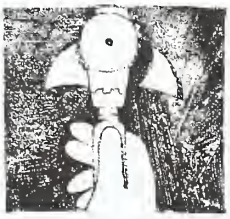
Vol. 2 No. 3 1978

Health Care Financing Administration

Forum

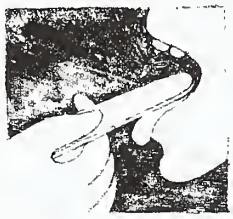


Children should be seen.



And heard.

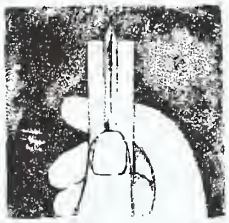
And ahhh'd.



And needled.

And measured.

And tested.



And charted.

And treated.

Preventive health services are important to vulnerable children . . . especially those from poor families, who have 3 times as much heart disease, 7 times the visual impairment, 6 times the hearing defects, and 5 times the mental illnesses. That's why there is an EPSDT program . . . Early and Periodic Screening, Diagnosis, & Treatment. Children in Medicaid families qualify for EPSDT.

Forum

Published by the Health Care Financing Administration of HEW.
Issued bimonthly by the Office of Public Affairs.

Volume 2 • Number 3 • 1978

Articles

Departments

U.S. Department of Health, Education, and Welfare
Joseph A. Califano, Jr., Secretary

Health Care Financing Administration
Robert A. Derzon, Administrator
Patricia Q. Schoeni, Director, Office of Public Affairs

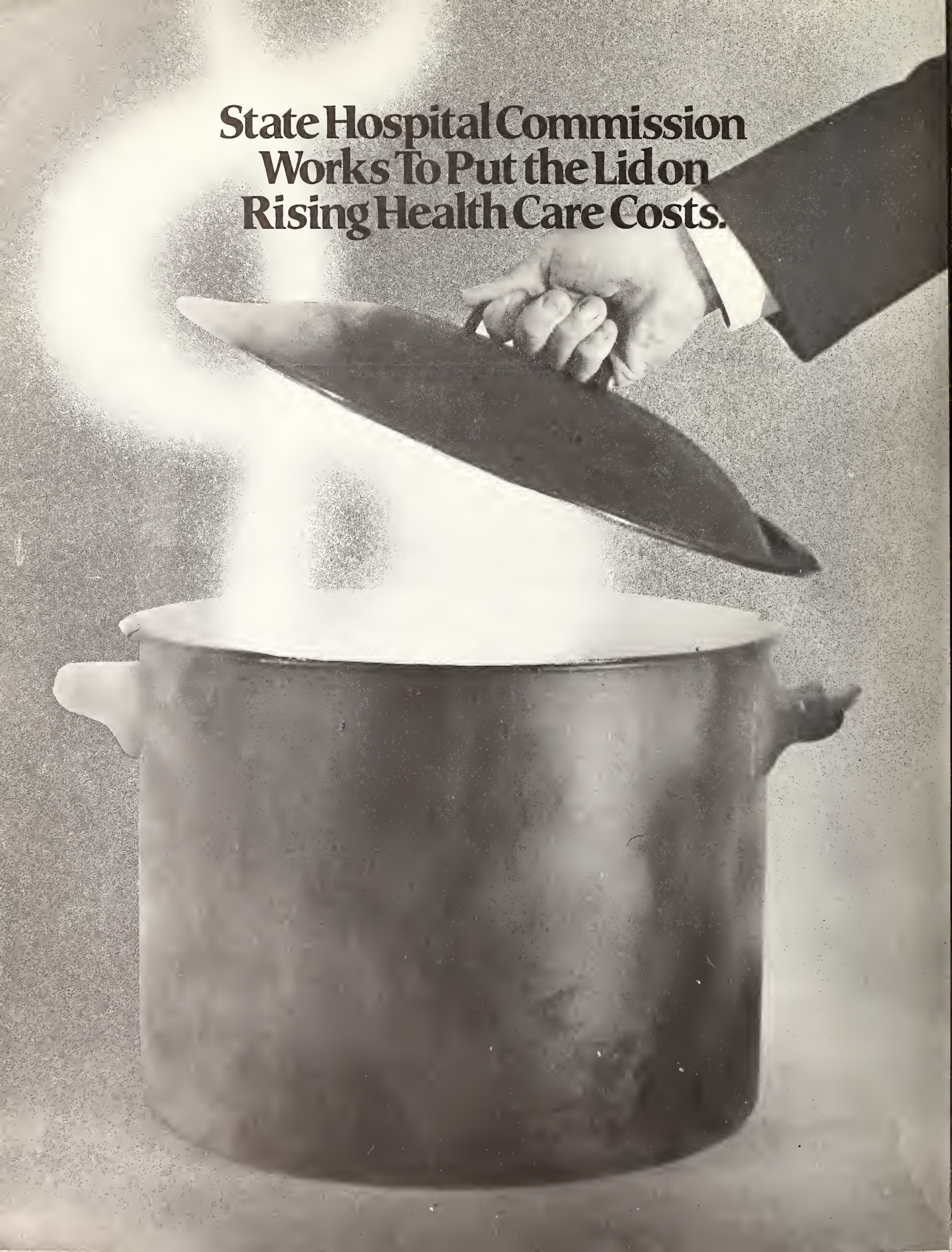
Martin Judge, Editor

Annual subscriptions are $6.75, domestic; $8.50, foreign, and are paid to the Superintendent of Documents, Washington, D.C. 20402. Single copy price is $1.20, domestic; $1.50, foreign.

Address manuscripts to the Editor, Room 5215, HCFA, MES Building, Washington, D.C. 20201. Telephone 202-245-0626.

Publication funds were approved by the Office of Management and Budget on Feb. 25, 1972, amended Dec. 4, 1973. Controlled circulation permit paid at Main Post Office, Washington, D.C.

State Hospital Commission Works To Put the Lid on Rising Health Care Costs.



by Francis Baker and Gregg Bennett

In 1977 while the national average rate per patient day increased 15.4 percent from the previous year, the average rate in Washington State increased only 11.9 percent. For 1978, Washington expects to hold its rate increase to 4.6 percent, compared with a projected national increase of 8.4 percent. This article explains the activities of the Washington State Hospital Commission which approves or disapproves rates proposed by the state's 116 private and public hospitals.

In 1973 a major legislative effort was initiated in Washington State to contain hospital cost increases which has resulted in a restructuring of the financial reporting system on which hospital reimbursement is based. Legislation established a state hospital commission with full authority to approve or disapprove rates proposed by hospitals. The thrust of the legislation was to promote effective and economical delivery of high quality health care services. The commission was charged with the responsibility for assuring that:

- Hospital costs are reasonably related to total services.
- Hospital rates are reasonably related to costs.
- Rates are set equitably among all purchasers of these services without undue discrimination.

The legislation required that an effective cost control program be established which would motivate hospitals to control their spiraling costs and assist them in doing so.

The concept of a state hospital commission was strongly supported by the Washington State Hospital Association, the Washington State Labor Council, major third-party payors, and both state and regional health planning agencies. The coalition of interests assured that the hospital commission was not created arbitrarily, but represented a reasoned and systematic approach to a rational control of the rate of increase in hospital costs.

Francis D. Baker, a former hospital administrator, has been executive director of the Washington State Hospital Commission since it was established.

Gregg Bennett is manager of research and development for the commission and holds a master's degree in hospital administration.

Results

While preliminary results of the cost containment strategies of the commission suggest that rates per admission and per patient day are significantly below the national average, further investigation is necessary before conclusive statements can be made. The commission's systems of reimbursement for hospitals, developed under a contract with the Health Care Financing Administration, are scheduled to be assessed by an outside evaluator under a separate contract between HCFA and the evaluator.

Average length of stay in Washington hospitals has traditionally been below the national average. (See accompanying table.) The projected length of stay in Washington for 1977 was 5.2 days—31 percent shorter than the projected national average of 7.5 days. This difference between state and national averages has repeatedly occurred since 1972 when the average length of stay in Washington hospitals was 27 percent below the national average, according to a survey by the American Hospital Association.

In 1976 there were 146 admissions to Washington hospitals per 1,000 persons, compared to a national average of 160 admissions per 1,000 persons. Inpatient days per 1,000 persons have ranged from 815 in 1973 to 813 in 1976, compared to a national average of 1,224 inpatient days for 1976. In 1976, Washington residents were hospitalized nine percent less frequently than the national average and experienced 34 percent fewer days of inpatient care.

Although total charges per admission in Washington have consistently been below national averages, they have increased between 1972 and 1976 at about the same percentage as the national averages. For Washington, the four-year increase was 65.2 percent compared to 63.2 percent nationally. The increase in charges per admission from 1977 to 1978 in Washington is projected at 4.6 percent, compared to a projected national increase of 10.0 percent. The average total charge per admission in Washington for 1978 is projected at $1,244.68 compared to estimates of the average national rate of $1,602.13 per admission. (See accompanying table.)

Due to more intensive services administered during a shorter stay, the average rate per patient day in Washington hospitals has consistently been higher than the national average. Between 1972 and 1976 the average rate per patient day increased slightly more than the national average. However, during 1977 the increase in Washington was 11.9 percent compared to a national increase of 15.4 percent. For 1978 an increase of 4.6 percent is projected for Washington compared to an 8.4 percent increase nationally. (See accompanying table.)

If rates per admission had continued to increase in Washington State in 1977 at the estimated national levels, the average rate would have been about $1,217.00 compared with $1,190.49. The resulting saving is $16,001,330 based on adjusted admissions of 603,596. Projections for 1978 suggest that the cost per admission in the state would have been $1,338.70 without the activities of the commission compared with an estimated state average of $1,244.68. The savings for adjusted admissions of 632,700 is about $59,486,454.

At the approved average rate per admission of $1,244.68, adjusted for outpatient revenue, the total estimated hospital revenue for 1978 is about $787,509,000. This results in a total "savings" during 1977 and 1978 of $75,487,784 or nine percent less than the expected national increase. While it cannot be concluded that this difference is directly attributable to the commission's actions, the difference does represent what could reasonably be expected if the rates of increase had continued at the national average.

Structure

The hospital commission consists of five members, appointed by the governor and confirmed by the state senate. It is generally representative of the interest of the consumer, labor, business and hospitals. Members serve four-year terms and receive no compensation other than reimbursement for expenses. The commission is supported by a full-time staff of eight and an executive director.

Costs of single department at one hospital compared with its peer group

If the hospital scores above the 70th percentile of its peer group in the first two categories **(Bold Numbers)**, then each category of costs is examined. In this case, the 70th percentile is 68.52 percent and the top two categories are each 85 percent. Each cost is also examined if a number of them are significantly higher than the 70th percentile.

	Peer Group 5				Hospital			Peer Group	Hospital
	Low	High	Median	70th Percentile	Variable Amount	Variance from Median	% Deviation from Median	Average Deviation from Median	Percentile
Total OP divided by 100 Billable CAP Units	40.93	87.39	64.15	68.52	83.80	19.65	30.63	18.57	**85**
Percent Change from Current Year	2.99–	335.04	6.81	9.85	323.39	316.58	4648.75	987.59	**85**
Total OP Expenses % Change from Current Year	1.62	18.42	12.93	15.57	12.72	.21–	1.62–	34.63	45
Total OP Expenses % Change from CY Approved	5.32	19.86	11.45	15.67	19.86	8.41	73.44	44.21	95
Salaries-Wages, EMP. BEN/100 Billable CAP Units	.00	47.05	27.78	29.61	47.05	19.27	69.36	26.58	95
Salaries-Wages/100 Billable CAP Units	.00	41.26	24.20	25.73	41.26	17.06	70.49	25.83	95
Professional Fees/100 Billable CAP Units	.00	6.40	.00	.00	.00	.00	.00	.00	40
Supplies Expenses/100 Billable CAP Units	.00	15.30	8.02	10.61	15.30	7.28	90.77	43.96	95
Percent Change from Current Year	3.64–	317.53	9.15	27.66	304.88	295.73	3232.02	792.66	83
Purchased Services/100 Billable CAP Units	.00	64.37	3.12	7.73	1.70	1.42–	45.51–	284.32	25
Depreciation Expense/100 Billable CAP Units	.00	5.71	1.88	3.66	4.23	2.35	125.00	72.81	75
Allocated Expenses/100 Billable CAP Units	5.55	22.14	14.80	16.07	21.64	6.84	46.21	24.85	85
All Other OP Expenses/100 Billable CAP Units	6.11–	4.59	.38	.76	6.11–	6.49–	1707.89–	415.52	5
Total Paid Hours/100 Billable CAP Units	.00	5.35	3.62	4.04	5.35	1.73	47.79	26.51	95
Salaries-Wages, EMP. BEN./FTE	12813.12	18306.07	16021.77	16682.09	18306.07	2284.30	14.25	7.22	94
Percent Change from Current Year	4.50	21.49	9.87	12.54	13.15	3.28	33.23	35.82	72
Salaries & Wages/FTE	11385.52	16052.13	13595.06	14578.19	16052.13	2457.07	18.07	8.40	94
Percent Change from Current Year	3.47	23.68	8.95	12.32	12.81	3.86	43.12	48.15	72
Billable CAP Units/Adjusted Admissions	105.36	485.63	236.62	370.77	128.67	107.95–	45.62–	49.22	15
Total Paid Hours/100 Total CAP Units	1.99	3.46	2.78	2.84	2.53	.25–	8.99–	11.51	39

Abb. Used: OP: Operating Expenses, CAP: College of American Pathologists, EMP. BEN: Employee Benefits, FTE: Full Time Equivalent

In addition, an 11-member Technical Advisory Committee, established by statute, represents hospitals, consumers, accountants and appropriate state agencies. The Technical Advisory Committee meets at the request of the commission to advise on matters of policy, proposed rules and regulations, and other matters.

Each hospital in the state is required to file a report defining its financial needs for the coming year and the rates it feels are necessary to meet those needs. The enabling legislation required the commission to allow rates sufficient to permit hospitals to render "effective and efficient hospital services in the public interest and in a solvent manner."

To carry out its responsibilities, the commission developed a uniform accounting system to be used by all hospitals. This system was developed following a review of the existing uniform accounting systems, advice from the Technical Advisory Committee, and with substantial input from the hospital industry in the state. A system was adopted in October 1974 after 10 months of development.

The system was designed not merely as a reporting system, but as a practical accounting system for direct application by hospitals to provide improved information for management. It establishes clear and specific definitions of each cost center and revenue center, including defined units of measure. It is adaptable to both automated and manual systems, and will accommodate large and complex hospitals as well as smaller and less complex institutions.

Budgeting and rate-setting

At the outset, the commission determined that it was administratively impossible to regulate every charge in each of the 116 non-federal hospitals under its jurisdiction. Following extensive discussions with various groups, the commission determined that a uniform budgeting system was essential, not only to meet the requirements of the statutes, but also to assure full and accurate explanation of the financial requirements of each hospital. With the assistance of a consulting firm, a budgeting system for hospitals was developed based on the uniform accounting system.

The entire budgeting sequence provides for the identification of all direct expenses by cost center by natural classification; the impact of charitable services, bad debts, and contractual allowances; and the recognition of additional financial requirements, such as working capital, described as "Planned Capital and Service Component."* This last item recognizes the aggregate of net changes in working capital requirements, debt retirement, capital expenditures for replacement of equipment, capital expenditures for new equipment, depreciation reserves and other specific requirements not ordinarily considered part of the operating expense budget.

These costs are offset by consideration of all sources of revenue, including depreciation for the coming year, transfers from restricted funds or special purpose funds, tax revenues or appropriations, nonoperating revenues applied to budget year needs, and other revenue sources appropriate to the financial requirements.

The net difference between income and costs is considered as the Planned Capital and Service Component. This system yields a specific dollar amount for each hospital, rather than a uniform percentage profit margin. In addition, the total budgeting system includes a three-year capital expenditure budget, projected cash flow budget, and projected financial statements, as well as a summary of the additional financial requirements. Each budget submittal includes prior year totals, current year estimates, including six months actual and six months estimated data, and projections for the coming year.

*Editor's note: The Health Care Financing Administration currently supports several state rate setting programs under its research and demonstration authorities. Such financial support is intended to provide HCFA with the opportunity to evaluate alternative hospital reimbursement systems and policies for possible general application, and does not imply approval of all policy decisions adopted in any particular program. In this case HCFA has not endorsed the commission's policy of including "financial requirements," as presently defined, in the determination of hospital service charges under the "Planned Capital and Service Component." Although the continued financial solvency of the hospital industry as a whole is clearly in the public interest, it does not follow that the solvency of each and every institution should be guaranteed in the rate setting process. Such a policy creates a set of incentives for hospital management that many regard as ill advised.

Hospital classification

Concurrent with the development of the budgeting system, the commission devised a system for classifying or grouping hospitals according to factors which influence costs.

The classification system that was ultimately developed incorporates 18 independent variables which were determined to have a statistically significant influence on hospital costs. These independent variables fall into two categories, external variables which are essentially beyond the immediate control of the hospital, such as the socioeconomic and demographic characteristics of the service area, and internal variables which focus on factors influencing the case mix.

A third possible group of variables, performance variables, was excluded from the system. Since one of the purposes of the grouping system is to identify hospitals with unreasonable costs, it was felt cost variables should not be included, since all the efficient hospitals would tend to be classified in one group and all inefficient hospitals would tend to be classified in another. Thus, there would be no basis on which to determine reasonableness of costs by comparisons within each group. A cluster analysis technique is used to determine the hospital groupings based on the 18 variables.

Budget review and analysis

The design of the budget review and analysis system is predicated on the legislative mandate to assure all purchasers that "hospital costs are reasonably related to total services, that hospital rates are reasonably related to total costs, and that such rates are set equitably among all purchasers without undue discrimination." The budget review process focuses on relating costs to services and follows through to determine reasonableness of the relationship between costs and rates.

The review of requested rates, which is performed by the staff, encompasses seven areas:

Charge per Admission

Year	Washington State	Percent Increase Over Prior Year	United States	Percent Increase Over Prior Year
1972	$ 637.79[1]		$ 788.51[1]	
1973	685.96[1]	7.6	839.52[1]	6.5
1974	743.12[1]	8.3	920.67[1]	9.7
1975	892.62[1]	20.1	1,093.95[1]	18.8
1976	1,053.61[2]	18.0	1,286.65[1]	17.6
1976	1,075.09[2]			
1977	1,190.49[2]	10.5	1,456.48	@13.2[3]
1978	1,259.04[2]	5.8	$1,602.13[4]	@10.0[3]
1978	$1,244.68[5]	4.6		

Charge per Patient Day

Year	Washington State	Percent Increase Over Prior Year	United States	Percent Increase Over Prior Year
1972	$110.83[1]		$ 99.97[1]	
1973	121.29[1]	9.4	107.30[1]	7.3
1974	132.65[1]	9.4	118.54[1]	10.5
1975	160.20[1]	20.8	142.00[1]	19.8
1976	189.46[1]	18.3	167.67[1]	18.1
1976	204.22[2]			
1977	228.54[2]	11.9	193.49[4]	@15.4[3]
1978	241.90[2]	5.8	$209.68[4]	@8.37[3]
1978	$239.14[5]	4.6		

1. American Hospital Association Guide to the Health Care Field
2. From budgets submitted by hospitals to the Washington State Hospital Commission
3. Silver, A. *Rate Controls*, January 1978 estimate of increase in rate per patient day and per admission
4. Estimated
5. Prospective reimbursement projected impact

- Hospital profile review.
- Volume analysis.
- Operating expense analysis.
- Analysis of additional financial requirements.
- Analysis of deductions from revenue.
- Analysis of a ratio of revenues to expenses.
- Analysis of performance compared with commission orders.

The hospital profile analysis includes a review of any changes in services, number of beds and medical staff composition, as well as any significant economic or demographic changes in the hospital's service area. The primary purpose of this review is to identify any significant changes that may impact volumes, operating expenses or other financial needs.

The analysis of each hospital's volume forecast includes a review of three years of trends in admissions, patient days and units of measure by department. Comparisons are made between projected annual volumes and volumes actually realized. Any significant changes found in the hospital's profile review are incorporated in the volume analysis.

The analysis of the projected operating expenses incorporates a complex expense screening system which compares each hospital's projected operating expenses to the operating expenses of its hospital peer group. In all, 19 cost centers, representing more than 90 percent of a hospital's costs, are screened in this process.

These screens are applied at two levels. The first is the primary or aggregate level, where projected total operating expenses are screened against six variables. These variables include total operating expenses per adjusted admission, total operating expenses per adjusted patient day, and analysis of operating expenses as a percentage change from the current year approved budget and current year estimated expenses. The expenses per admission and per patient day are also computed as a percent change from the current year's estimated expenses.

In addition, 49 explanatory variables relating to aggregate budgeted costs are evaluated. These variables identify costs by natural classification such as salaries and wages, professional fees, supplies, purchased services, depreciation, interest and other direct costs. If a hospital's operating expenses are in the top 30 percent of its peer group of hospitals in any of the six primary variables, the hospital's total expenses are reviewed at the departmental level.

The secondary and detailed screening level is designed to identify the impact on total costs and costs per unit of service resulting from changes in: (1) price level, (2) productivity, and (3) intensity of services.

Each of the 19 departments selected for review is screened against 17 variables comparing a hospital's budget request with the averages for its peer group of hospitals. In all, more than 570 variables are evaluated in this process. Any expense that is in the top 30 percent of the peer group's expenses requires justification.

In addition, comparisons are made between the current year, the prior year, and the year for which the budget request is made. For example a hospital might request additional staffing while experiencing declines in volume within a department. This would result in a decline in productivity, compared with the previous three-year period. If such additional staffing would place the hospital above 70 percent of its peer group in productivity, the costs of additional staffing requested would be disallowed unless justified by the hospital. See the accompanying table for an example of the screens applied to one department.

The analysis of the additional financial requirements includes a complete review of a hospital's projected financial position compared to its current position, the need for additional working capital, including changes in accounts receivable and accounts payable, transfers of revenues from designated funds or restricted accounts for the budget year, and changes in other assets and

Average Length of Stay

Year	Washington State	United States
1972	5.74[1]	7.89[1]
1973	5.66[1]	7.82[1]
1974	5.60[1]	7.76[1]
1975	5.57[1]	7.70[1]
1976	5.56[1]	7.67[1]
1976	5.26[2]	7.67[1]
1977	5.19[2]	7.53[3]
1978	5.19[2]	7.64[3]

1. American Hospital Association Guide to the Health Care Field
2. From budgets submitted by hospitals to the Washington State Hospital Commission
3. Silver, A. *Rate Controls*, January, 1978 estimate of increase in rate per patient day and per admis

liabilities. Net working capital increases, if any, are determined following the analysis of all sources and uses of funds.

In addition, an analysis is performed of other financial requirements, including existing debt, costs for new equipment and replacement equipment, funding of depreciation reserves after allowing for replacement costs, and others. A detailed analysis is also made of the sources of funds including depreciation expense, transfers from existing reserves, tax revenues, and appropriations, transfers from restricted reserves, and the application of other operating or nonoperating revenues.

The commission does not force hospitals to use all reserves in an effort to hold down rates. Rather, it strongly encourages hospitals to maintain depreciation reserve accounts in order to reduce the impact on rates in future years as replacement of equipment and repairs to facilities become necessary. No capital expenditures are approved, however, until a certificate of need has been approved by the state.

Projected deductions from revenue, including contractual allowances, bad debts and charity, are also analyzed prior to final action on the rate request. Comparisons are made between the hospital's projected deductions by specific category and those of the peer group of hospitals. In addition, the hospital's experience is also analyzed and compared to the budget year request. Any significant increase requires justification.

A departmental analysis is conducted by comparing the financial needs of each department with the revenues expected to be generated from the proposed rates. This ratio analysis is to determine the extent that one department of a hospital is subsidizing various other departments. If this subsidy exceeds plus or minus five percent, it is routinely disallowed by the commission unless the hospital is able to justify a higher percentage.

In certain hospitals, particularly rural ones, the commission has allowed some subsidizing of certain departments such as the labor and delivery and obstetrics services since such hospitals provide the only service available to a significant geographical area.

The final portion of the total analysis of financial needs is a review of the hospital's performance against rates previously approved by the commission. The staff determines the degree to which hospitals have:

- Improved productivity.
- Used revenues allowed for additional financial requirements.
- Maintained a cost-related pricing system.

While adjustments to rate requests are not directly affected by this review, it does serve to alert both the hospital and the commission to areas of potential problems. Experience to date indicates that most hospitals make a diligent effort to comply with the commission's determinations, and that this review is useful to them in managing their operations.

Public hearings

Following the complete analysis by the commission staff, a detailed report is submitted to the hospital, to each commission member, and to each of the major payors. Fifteen days after the report is distributed an informal public hearing is held and the hospital's rate requests and the recommendations of the staff are considered. At that time the hospital has an opportunity to provide additional justification for the rates requested and to make adjustments to its request.

If a hospital is dissatisfied with the commission's action, a petition for a formal hearing by the commission may be requested. If a hospital is dissatisfied with the results of the formal hearing, it can appeal the ruling in the courts.

The formal hearing and appeal process are presently untested, since in the three years that the commission has acted on proposed rates no hospital has as yet found it necessary to seek a formal hearing or judicial consideration.

Reimbursement

It was recognized at the outset that due to the variety of reimbursement systems being used, including Medicaid, Medicare and private insurance companies, that all payors were not receiving equitable treatment. Therefore, the commission was given authority to try to develop a better method of reimbursement.

Previous research and demonstration projects suggested that there is an incentive to produce more units of service when reimbursement is based on a fee-for-service system, or a rate per unit of service. It has also been demonstrated that a cost reimbursement system has built in disincentives to contain costs.

Collectively, the incentives of a cost reimbursement system encourage the delivery of more units of service to more patients over more days of hospital care. Since Medicare and Medicaid use a cost reimbursement system and represent about 40 percent of total hospital charges, the disincentives for overall hospital cost containment are very significant.

A second major concern was the costs that were disallowed by payors who reimburse hospitals on a cost basis. Since most of these payors reimburse only a percentage of costs, the difference must be passed on to charge-based payors. For example, in a hospital which receives 50 percent of its reimbursement from cost-reimbursement payors, each dollar of cost disallowed by those payors necessitates an increase of a dollar in the rates charged to the charge-based patients. This problem of rates is further compounded by the fact that different payors set different limits on the costs they will pay for various services.

The commission developed a reimbursement system designed to address equity among purchasers by identifying those characteristics of each payor's reimbursement system which do not cover the costs incurred by the hospital. Each purchaser would therefore be responsible for the reimbursement of specific costs of the individual payor.

Since it was recognized that hospitals have been observed to adjust their admission and treatment practices to maximize revenues, various choices of the unit of payment were studied in an effort to both constrain excessive use of services and contain the cost

per unit of service. Studies have shown that if a hospital is reimbursed according to the number of admissions, there is a tendency to shorten the lengths of stay and admit patients more often. On the other hand, if hospitals are reimbursed on the basis of a patient day, there is a tendency to extend the length of stays and the number of admissions.

To demonstrate the impact of different units of payment on hospitals, the commission proposed to the Social Security Administration that three different types of reimbursement be used concurrently in three groups of the hospitals throughout the state, each group consisting of about one-third of the hospitals.

Type I reimbursement incorporates incentives for control of both cost and volume. Under this reimbursement method, hospitals were guaranteed in advance a lump sum reimbursement representing 55 percent of the hospital's revenues approved by the commission. If a hospital's projected costs or volumes could be maintained at lower than projected levels it would realize additional reserves for meeting future needs for additional services or equipment. However, if the hospital's costs or volumes exceeded the forecasts, reimbursement would not be adjusted based on actual costs incurred.

Type II reimbursement was designed to test the incentives for cost control, but without an incentive or disincentive for volume. Reimbursement was based on a rate of service established by the commission. The four major payors would reimburse each hospital on the basis of adjusted billed charges, which reflected the same principles of payor costs differentials which are also incorporated in Type I reimbursement.

Type III reimbursement was proposed as a continuation of the existing reimbursement systems, including the customary retrospective cost reimbursement employed by Medicare and Medicaid. Type III reimbursement hospitals were envisioned to serve as one control group to evaluate differences in performance under reimbursement Types I and II. A second control group will likely include a sample of similar hospitals outside the state.

Under Type I reimbursement, costs are allocated to each payor on the basis of its historical share. Once the share has been determined, each of the payors reimburses the hospital for the amount determined without subsequent modifications to cover fluctuations in actual costs or volume. Under this form of reimbursement, patient billings no longer serve as the direct basis for determining payment.

Operationally, a payor reimburses each hospital semi-monthly. The semi-monthly payments are adjusted quarterly to reflect changes in a payor mix. A limit is placed on revenues from other payors through fee-for-service payments to assure that revenues are not accumulated above the budget approved by the commission.

Under Type II reimbursement, hospitals are reimbursed by all payors on the basis of charges. As in Type I reimbursement, modifications are made in each payor's share based on the demonstrated cost differentials. Based on the adjusted shares, a percentage of charge ratio is determined for each payor. As in Type I, no final settlements are made at year end for actual costs.

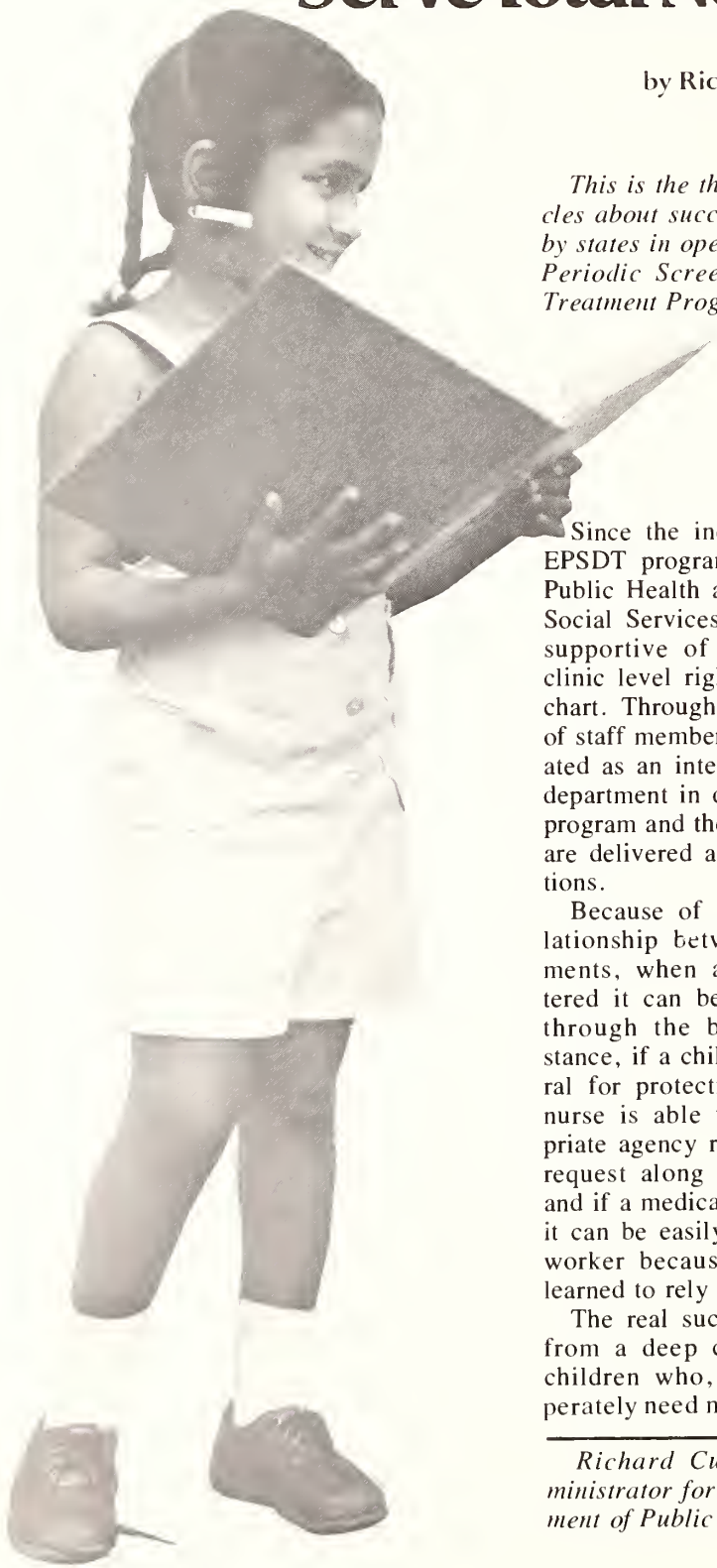
Compliance

Each hospital is evaluated at year end for compliance with approved rates and total revenues. A marginal cost allowance is made to reflect the additional costs related to volumes over projections for hospitals under Type II and Type III reimbursement. Volumes below the forecast result in adjustments to redistribute the fixed costs over the reduced volumes. A similar methodology is applied to "other" revenues, which include self-pay and commercial insurers, under Type I reimbursement when total actual revenues exceed the total allowable revenue approved by the commission.

Hospitals have an opportunity to provide justification to the commission for all or part of revenues in excess of approved levels. Revenues determined to be in excess are then adjusted from approved total revenues in the next full fiscal year. ■

Social Services Approach Helps EPSDT Program Serve Total Needs of Children.

by Richard Currier



This is the third in a series of articles about successful techniques used by states in operating their Early and Periodic Screening, Diagnosis and Treatment Programs.

Since the inception of Michigan's EPSDT program, the Department of Public Health and the Department of Social Services have been extremely supportive of each other from the clinic level right up the organization chart. Through the individual efforts of staff members, both agencies operated as an integrated human services department in developing the EPSDT program and the social services which are delivered as a result of examinations.

Because of the good working relationship between the two departments, when a problem is encountered it can be moved very quickly through the bureaucracy. For instance, if a child needs a quick referral for protective social services, a nurse is able to contact the appropriate agency rather than passing the request along to the social worker; and if a medical referral is necessary, it can be easily arranged by a social worker because the providers have learned to rely on their judgment.

The real success of EPSDT stems from a deep concern for the poor children who, in some cases, desperately need medical care.

Richard Currier is EPSDT administrator for the Michigan Department of Public Health.

Perhaps the best evidence that this integrated effort works in Michigan are examples of how children and their families have been helped. It should be noted, however, that these examples are far from the typical cases encountered in examination, and serve only to illustrate the approach.

One seven-year-old boy, for instance, at his initial examination, was found to have scars over most of his body including a healed stab wound. He appeared frightened of his father, urinated on the floor, listlessly rocked back and forth with a far away stare, and was unable to respond to questions. His three-year-old brother had a crusty scalp, diaper rash and poor hygiene.

The father explained to the nurse that he felt that his four-year-old son needed a psychological examination. He wanted the examination kept a secret from his wife. The boy had scars because he was "clumsy." Child abuse proceedings were begun and a public health nurse was sent to the home. Frequent consultations were necessary between the clinic staff, field nurse and the protective service worker.

Some months later, the clinic nurse was contacted by a doctor regarding immunization of the four-year-old who he was treating for burns on the upper and lower lips. While reporting the incident to the protective service worker, the screening nurse scheduled a rescreening for the children. Since their conditions had not improved, action was taken to make the children wards of the court in the parents' custody.

The youngest and the oldest children were also scheduled for a rescreening long before the normal time interval. The mother brought in two children, a newborn and a child of 13 months who was not yet walking and weighed 19½ pounds. The newborn has gastroenteritis and conjunctivitis. The mother explained that she was now separated from her husband. She slept on the floor and felt too tired to care for the children properly. The nurse arranged for supplementary food for the mother.

Following that visit to the clinic, it was felt that a conference should be held of all agencies dealing with the family. Present were the coordinator of EPSDT, the outreach worker, the Medicaid supervisor, the public health nurse, the screening nurse, the nurse supervisor, the protective service worker, and the clinic manager. During the conference views were exchanged, goals established and a service plan determined.

It is clear from this example that follow-up is more than just making sure the family keeps a doctor's appointment. Treatment is more than providing a miracle prescription. Many different types of health providers are involved, demanding extensive coordination over a period of time. Moreover, this example is not an isolated one but a frequent occurrence in clinics serving low income families. Several other examples underscoring the social services approach are cited in the accompanying box.

A nurse, two health technicians, a clerk and a half-time public health nurse are assigned to a clinic performing about 4,000 examinations per year. In all there are 110 clinics. The

outreach function, where children eligible for examination are sought, is carried out by workers who often have other duties in all counties except in the state's most populous, Wayne County. In this county, which contains Detroit, an outreach team is assigned to each clinic.

A team is composed of three outreach workers, a transporter, a clerk and a team coordinator-worker. In some cases, roles are shifted so that the clerk can assume the role of an outreach worker, giving the team four outreach workers with each doing much of his own paperwork.

Previously, Detroit's outreach teams were centralized and covered three or four clinics, but it was found to be more effective for a smaller team to be assigned to each clinic. This is because the team members can see the process and the importance of their roles in the program. There is also a greater feeling of satisfaction due to the aspect of job completion. In addition, outreach teams based at a single clinic can become involved in the treatment process and can encourage the children and their parents to keep appointments for treatment and follow basic preventive health practices, such as

The Integrated Approach.

Without an integrated approach to EPSDT, coordination of services could slow significantly and the time lag could complicate the problems of the children and their families. Some examples:

• A 22-year-old mother brought her five and six-year-old daughters in for examination. During the examination the mother took tranquilizers explaining to the nurse that she had been in a mental institution and the drug had been prescribed by her physician. Upon further inquiry it was learned that because of the mother's frequent stuporous state, the children were often left without supervision. At times her daughters had been sexually molested. To the relief of the mother, the nurse immediately dispatched a public health nurse to arrange the transfer of the children to a foster care home. The mother was placed under psychiatric care.

• In one instance a mother brought in her apparently retarded son for examination. She explained that delivery of the child had been extremely difficult and that the attending physician had been convinced that the child would be retarded. From that time on, the mother treated the child as if it were retarded and by so doing had produced this apparent condition in her son. With some counseling and repeated visits to monitor progress, the boy is now well on his way to normal development.

• A 25-year-old widowed mother of three small children appeared one morning at a clinic in Detroit. The examining nurse noticed that the children were exceptionally nervous and frightened. All did poorly on a test to measure language and social and motor development. As the testing procedure continued, the mother sat passively staring into space while her children proceeded to tear the clinic apart. Under examination, the children were found to be dirty and spotted with sores from impetigo.

At the conclusion of the examination, the nurse reviewed the findings with the mother. She said she had noticed the sores on her children, but did not know how long they had been there nor what should be done about them. The mother expressed special concern for her three-year-old daughter, who frequently cried uncontrollably for no apparent reason.

Upon further questioning, the mother explained that she had been hospitalized for nervous breakdowns five times since the death of her husband two years previously. She said that she would frequently sit in the presence of her children and cry and scream. At other times, drained of all emotional strength, she would sit daydreaming for long periods.

The nurse suggested that the children be placed in a day care center and arranged transportation for them. In this way, the children could have a stimulating environment and the mother could get the rest she needed.

A few weeks later, the same family returned to the clinic. The change was remarkable. Mother and children were clean and neatly dressed and all were cheerful, outgoing and responsive. The mother smiled and manifested a gentle but firm control over the children. It was apparent that the children were living in a stable environment in which continued physical and emotional development was possible and all three could be expected to mature as productive adults. The mother reported that she had enrolled in a job training class at an automobile manufacturing plant.

This family is not exceptional. Many other instances, each a variation on the same theme, could be cited. What is clear in this case, as well as in many others, is the humanitarian and economic benefits of preventive care. Amazing results were obtained with a minimal effort because the help came in time. The pay-off will continue for years, not only in tax money saved by avoiding possible institutionalization—at about $20,000 a year per person—of this family and others like it, but also in years of work the family members will be able to contribute for their own benefit and that of society. ■

maintaining proper diets.

While there has been great enthusiasm on the part of outreach workers, the sheer caseload weight and the entrenched poor economic conditions of Wayne County never allowed it to score well in case findings or referrals. To help correct this, the University of Michigan's School of Public Health was asked to design a course of study for the outreach workers. It is believed that this is the only such course in the country. Those successfully completing the full semester course will receive continuing education units from the University of Michigan.

The classes which run for seven months are held in four locations near the clinics where the workers are based. The cost of the training is about $300 per person. The outreach workers spend one day every other week in class. In the morning there are lectures and in the afternoon the workers carry out assignments. The first class will complete the course in November. If the results are as positive as expected, the course will be offered in other counties.

Many of Wayne County outreach workers were born in the community in which they are now working, which is a plus. But they often lack an understanding of the value of preventive health practices and communications skills. The course was designed to address these subjects and others including:

- The resources in the community that can be drawn upon to help the children.
- Usual problems affecting the socioeconomic group, such as alcoholism, drug abuse, one-parent families and employment problems.
- Methods for dealing with aggressive attitudes; how to conduct better interviews and help parents and children understand the importance of the program through salesmanship.

Since each county is responsible for its own EPSDT program, it has been difficult to determine such things as how outreach workers contact those eligible for the program, the techniques they find successful and the ones that should be avoided. To remedy this lack of information, a monthly report form has been devised which lists the type of contact made, frequency and action taken. The form is now being field tested in Wayne County and is expected to be used throughout the state after a shakedown period.

Michigan was among the first to plunge into the massive preventive health program enacted by Congress in 1968. Early on in the EPSDT program, it was recognized that in order to assure an effective program, staff members must in some cases go beyond the basic requirements. For instance, the parents or guardians of each child are interviewed extensively to establish a clear picture of the environment in which the children live.

There is an emphasis on preventive practices. If an interview uncovers that a parent or guardian lacks sufficient knowledge to prepare nutritious meals or properly care for the children, a public health worker will go into the home and demonstrate the necessary procedures.

Since the first child was examined in Michigan in 1973, nearly a half million children have received comprehensive examinations. In 1974 155,763 children were examined. That number declined to 114,655 in 1976 and leveled off in 1977 to 114,992. Children over one year of age are eligible for examination every two years. Experience has shown it more efficient to examine entire families at once because of the difficulty of insuring that appointments are kept.

We are watching statistics closely to find where we are not progressing as we had anticipated. For instance, 69 percent of black children examined are referred for treatment compared with only 54 percent of white children examined. Given the time span our program has been in operation, the percentage of black children needing treatment should be less. This means that there has been less success in finding black children in need of treatment or in insuring they receive treatment for problems discovered during examination. Although both percentages have been falling steadily, this problem is being worked on and it is one reason we have begun training outreach workers in Wayne County, which contains a large percentage of black children eligible for the program.

Overall, the most remarkable decline in referrals has been the dental referral, which means these problems are being treated.

Because of well-publicized cases of welfare abuse, the public tends to overlook the unpublicized efforts of many providers who take a genuine interest in their clients and follow through with extensive health services. In a recent study examining referrals for health care in Michigan, it was found that 83 percent of clients referred for care received treatment for at least one problem found during examination and 78 percent of all problems were treated.

Follow-up efforts at times border on the heroic, as happened recently in Lapeer County. A young boy suffered from malocclusion because his front teeth protruded. Since it was impossible for the boy to close his mouth, saliva drooled from his lower lip.

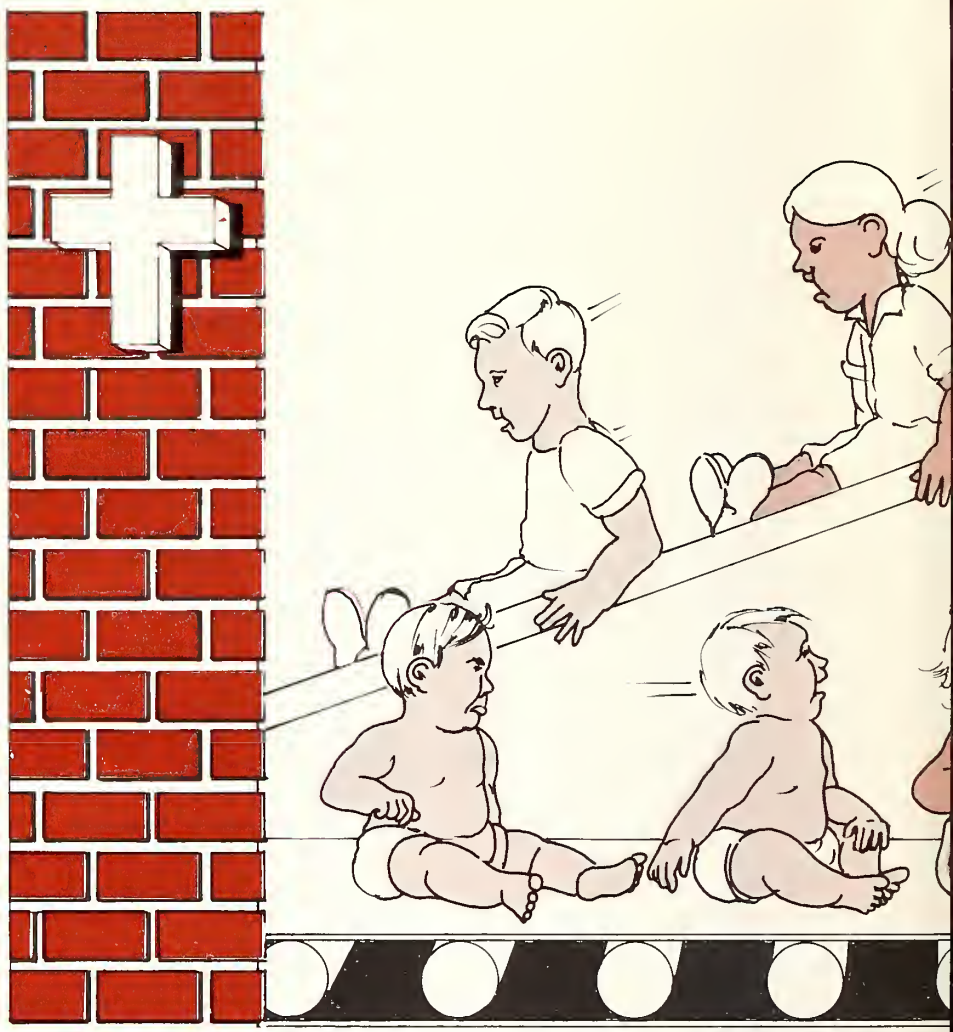
The boy had great difficulty keeping food in his mouth and found it almost impossible to chew food properly. Lunch time at school was a miserable experience as his classmates teased and laughed at him because of his "Mortimer Snerd" appearance. His mother discovered that because of this ridicule, he often skipped lunch. The lad was referred to a dentist for needed care. Although the dentist could not obtain Medicaid reimbursement for orthodontia, he agreed to follow-up on the referral and the family paid whatever they could, sometimes only a dollar a month.

One year later, the family reappeared at the clinic for another examination. At first team members were unable to recognize the boy. His mouth closed normally, he appeared happy, had an improved posture and an air of confidence. He was doing much better in school and had many new friends.

EPSDT, with its emphasis on preventive health care, is an important step in facing up to the responsibility of providing for the health problems of needy children. The wealth of a country is in the good health of its children, for without a foundation upon which to build a strong nation is lacking. ■

Two Hospitals Consolidate Services to Save $375,000 Annually.

by Mark Chambers
and Richard Russell



The problem of excess hospital capacity in the seven counties of southeastern Wisconsin is no different than that which exists throughout the country. In an effort to reduce this excess capacity, the Southeastern Wisconsin Health Systems Agency has begun performing analyses of each department of the 31 hospitals under its purview.

One such analysis was performed on the obstetrical units of each hospital, and eight of the 26 units were found not to meet the standards for continued operation. In several cases the recommendation was categorically to terminate the inefficient obstetrical units. In most cases, however, it was recommended that further study be made to assure that terminating the units would not impair the viability of otherwise stable community hospitals.

In the case of two hospitals further study showed that if the obstetrical units were consolidated, there would be a saving of about $250,000 per year. But the hospital closing down its unit would sustain a substantial loss of revenue. To balance this, the hospital receiving the consolidated obstetrical unit would close down its pediatric unit in favor of the other hospital. An analysis showed this would save an additional $125,000 annually for a total annual saving of $375,000.

The two hospitals trading units are both in the city of Kenosha, midway between Milwaukee and Chicago. St. Catherine's hospital, which has 260 beds, serves about 41 percent of the area's patients; Kenosha Memorial, which has 352 beds, serves about 54 percent of the patients in the area.

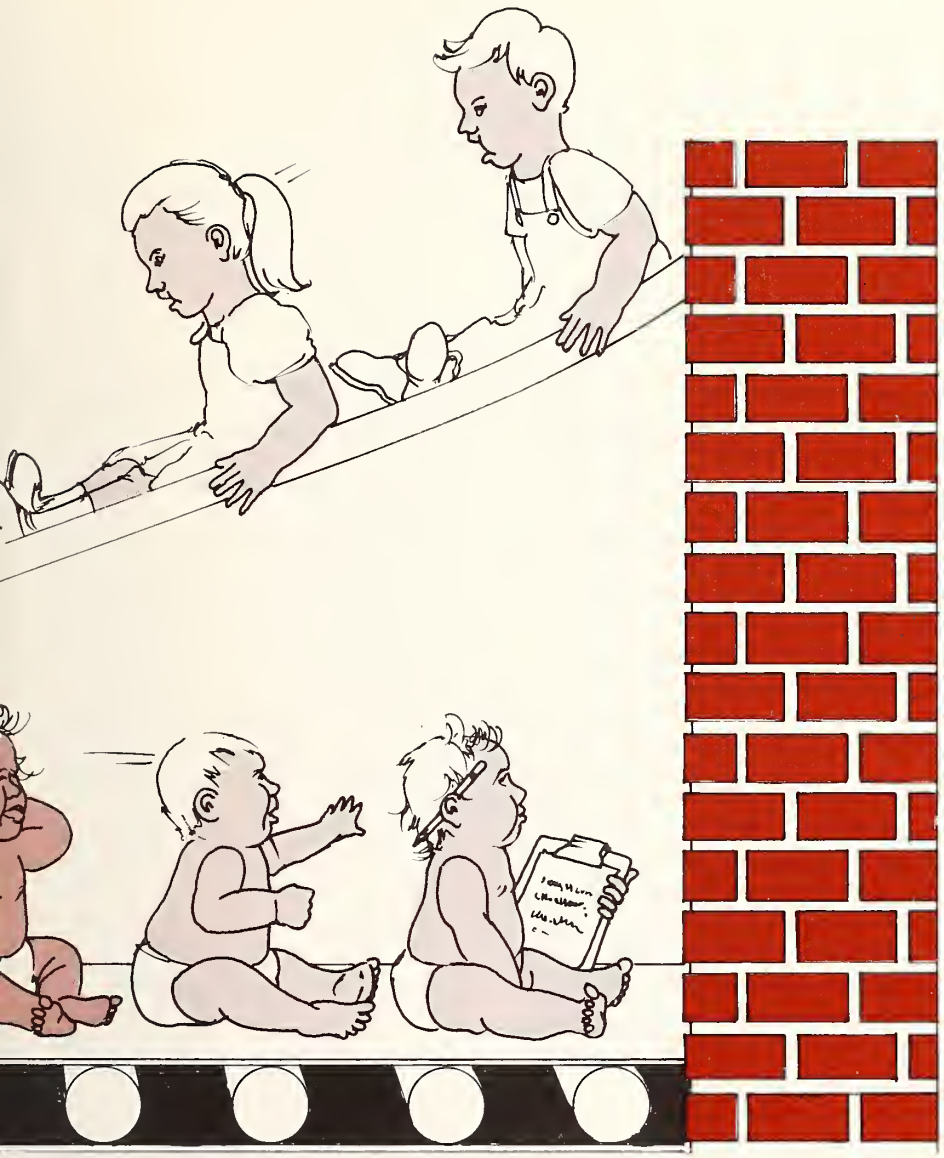
Each hospital's volume of deliveries per year is only about half of the 1,500 deliveries per year required to meet the recommended minimum for an urban hospital's obstetrical unit. The recommended occupancy rate for hospitals is 80 percent and in 1977 Kenosha Memorial's occupancy rate was 67 percent while St. Catherine's was 66 percent. Since the hospitals were so closely matched, the decision on which should close its unit with the least adverse impact on its own viability and on the community it served was difficult.

Saving with consolidation

To determine whether or not a cost reduction could be effected through a consolidation of obstetrical units, a comparison was made of the variable costs of each unit at their current number of deliveries (825 and 785) and the projected variable costs of operating a single obstetrical service capable of 1,600 deliveries a year.

Variable costs include nursing staff, supplies, drugs, printing and stationery and certain items of equipment. The analysis focused on nursing staff costs since it is the greatest cost category.

Mark Chambers is director of the Health Systems Development Division of the Southeastern Wisconsin Health Systems Agency, Inc. and holds a master's degree in public health. Richard J. Russell is the senior planner of the Health System Development Division and holds a master's degree in public policy and administration.



The analysis indicated that operation of a single obstetrical service with a volume of 1,600 deliveries requires 19 fewer full-time nursing positions* than the operation of two obstetrical units at about 800 deliveries each. The annual nursing staff cost at a single merged facility was projected at about *$750,000* a year, compared to a cost of $539,624 for 825 deliveries at Kenosha Memorial and $433,315 for 785 at St. Catherine's.

Repercussions of consolidation

If the consolidation of the obstetrical units were to result in an escalation of total costs at the hospital losing a unit, then the economic benefits of the merger would be diminished accordingly. This is because the amount of the loss must be redistributed to other units, resulting in higher costs to patients.

From its obstetrical unit, Kenosha Memorial generated a net revenue from routine daily patient charges of $80,436 after direct operating expenses and a net gain from ancillary services to patients of $133,797. Terminating this unit, then, would create a net loss for the hospital of about $214,233 annually.

The data for St. Catherine's indicated that its obstetrical unit generated a net revenue from routine daily patient charges of $151,394 after direct operating expenses and a net gain of $93,595 from ancillary services. Termination would create a net loss of about $244,989 annually.

Inasmuch as a substantial proportion of total costs is fixed, the hospital terminating its OB unit would require an upward adjustment in its rate structure in order to maintain financial stability.

Unit trade-off

One approach to avoiding a negative fiscal impact on one of the hospitals is the replacement of its obstetrical unit with another revenue-generating unit. In search of this replacement, an analysis was conducted of the inpatient pediatric unit at each hospital because they were historically under utilized.

The agency's guidelines call for a pediatric service in urban community hospitals to have a minimum of 20 beds with a minimum occupancy rate of 75 percent. Although both units met the size guideline, the occupancy rates were 58 percent for Kenosha Memorial and 43.8 percent for St. Catherine's.

The extent of the cost savings effected by a consolidation of pediatric services was determined in the same way as the analysis of obstetrical units. The data indicated that operation of a single merged pediatric unit would require 14 fewer nursing positions than the operation of the two units. The study concluded that a consolidation of pediatrics would yield a savings of $125,000 annually.

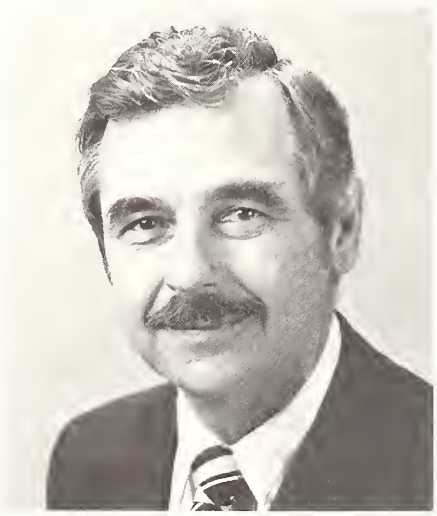
The study also indicated that in 1977 the obstetric and pediatric units at the two hospitals were approximately equal in their contributions to hospital overhead. Thus, in addition to generating an operating cost savings, a consolidated pediatric unit would constitute a financially equitable replacement service for the hospital terminating obstetrics.

Conclusion

On May 5, 1978, Kenosha Memorial and St. Catherine's Hospitals announced they would undertake a consolidation of their obstetrical and pediatric units, emphasizing the economic benefits to the community.

The health systems agency is in a unique position to serve as a catalyst in bringing about voluntary cost containment actions. Success in bringing these actions about will be dependent on the agency's skill in increasing community awareness of the problem of excess hospital capacity and the ability to document the benefits of its reduction. ■

* Full-time equivalent positions



Richard Heim appointed Medicaid Director.

Richard W. Heim, former executive director of New Mexico's Health and Social Services Department, has been named head of the Medicaid Bureau by Secretary Joseph A. Califano, Jr.

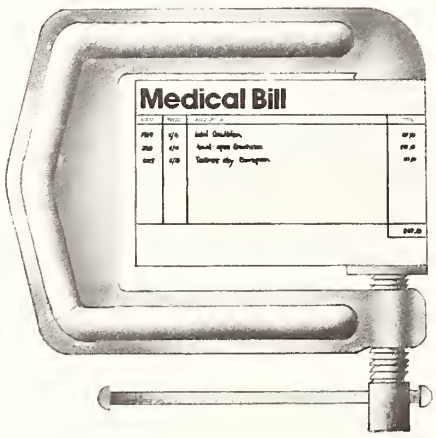
Mr. Heim joined the state agency in 1971 and within four years moved his department budget from a $4.5 million deficit to a $5 million surplus. Under his leadership, New Mexico was the first state to receive Federal certification of its mechanized processing system for Medicaid claims and was among the first to receive designation as a Professional Standards Review Organization (PSRO).

Mr. Heim originated the homemaker-home health aide program to serve the elderly and disabled, and experimental programs in primary health care, using physicians' assistants to serve remote rural communities.

"Dick Heim brings to the Medicaid Bureau the valuable asset of having worked closely with several state governments, and he has earned the high regard of state Medicaid directors," said Robert A. Derzon, HCFA Administrator. "His accomplishments during an outstanding career demonstrate both his commitment to helping the poor of our country and his management skills in initiating creative ways to meet that commitment."

Earlier in his career, Mr. Heim was manager of Bernalillo County in Albuquerque, and subsequently served as acting director of the University of New Mexico's Division of Public Administration. He served in Washington for three years as administrative assistant to U.S. Senator Clinton P. Anderson, a prominent figure in health legislation and one of the prime sponsors of the original Medicaid and Medicare legislation.

From 1975 to 1978, Mr. Heim served on the Advisory Committee on National Health Insurance for the House Ways and Means Committee's Subcommittee on Health.



Ceiling imposed on physician increases.

A five percent ceiling on fee increases paid to physicians for the next 12 months is being imposed by Wisconsin's largest prepaid medical-surgical insurer, Surgical Care, the Blue Shield plan of the Medical Society of Milwaukee County.

The ceiling, which is unprecedented in the health insurance field, became effective June 1.

Responding to the imposed ceiling, the State Medical Society issued the following statement: "We accept the good intentions of Surgical Care and the Medical Society of Milwaukee County but point out that doctors' office overhead and general inflation are increasing at the rate of 10 percent, twice as fast as the limit imposed by Surgical Care.

"It should be remembered that the annual increases in physicians' fees are only a small fraction of one percent of the total cost of medical care in Wisconsin. A five percent ceiling imposed on only one small segment of the population under these circumstances can succeed only if all other elements of society immediately follow the same course."

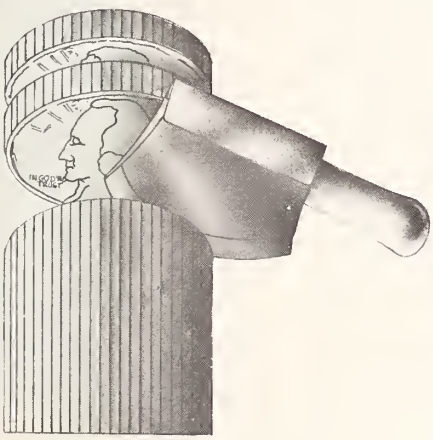
Surgical Care has limited increases in prevailing physicians' fees to about the level of increase in the consumer price index since 1966.

New HCFA rulings booklet to be published.

A new booklet containing a variety of rulings on Medicaid and Medicare programs will be published shortly. The booklet, *Health Care Financing Administration Rulings,* contains final opinions, including concurring and dissenting opinions, and orders made in the adjudication of cases; statements of formal policy and interpretations adopted by HCFA or one of its components not published in the *Federal Register;* indexes of administrative staff manuals; and instructions to staff that affect members of the public.

For example, *HCFA Rulings* will publish significant decisions on HCFA programs by federal courts, administrative law judges, and the Appeals Council of the Social Security Administration, the Provider Reimbursement Review Board, the Administrator (on behalf of the Secretary) and opinions of the General Counsel.

The booklet will be published quarterly and updated periodically. Copies are available at Room 153, East High Rise Building, Stop 127, 6401 Security Blvd., Baltimore, Maryland 21235.



Cost saving measures to save billions.

New measures designed to save billions a year in federal and state expenditures for Medicare and Medicaid were recently announced by HEW Secretary Joseph A. Califano, Jr. A small annual savings would begin accruing this year and would grow to $56 billion in fiscal 1983 when all the elements are implemented.

In announcing these measures, Califano noted that from 1975 to 1977 the cost of medical services rose by 9.5 percent—more than one-and-a-half times the increase in consumer prices for that period.

The cost saving projects include:

- Regulations limiting Medicare payments for laboratory tests and medical equipment to the lowest price that is widely available, rather than allowing payment for average charges or even higher than average charges. Currently, laboratories and manufacturers can increase their Medicare payments by raising their prices without justification.

Initially, the limits will apply to 12 laboratory tests, which account for 50 percent of the tests paid for by Medicare, and two of the most commonly purchased pieces of medical equipment, hospital beds and wheelchairs. These limitations should stimulate substantial competition among suppliers, particularly independent laboratories.

- More stringent computer screening techniques like those used by the IRS will be used to identify questionable health care services. Those identified will be subject to a complete audit. Until now, screening standards have been left to the judgment of individual Medicare insurance carriers, based on local experience.

- Standards for lengths of stay in hospitals and nursing homes will be developed with the help of local Professional Standards Review Organizations (PRSOs). By year's end, PSROs will be reviewing more than 60 percent of the Medicare and Medicaid hospital admissions to assure the patient needs hospital care, that the length of stay is not excessive and that all services provided by the hospital are completely necessary.

- A program designed to reduce the amount of unnecessary surgery by paying for an opinion by a second physician will be accelerated. HCFA will establish a network of physicians willing to provide second opinions on surgery and on other medical procedures. A consumer information campaign will begin shortly to make Medicare and Medicaid beneficiaries aware that the opinion of a second physician will be paid for by the Government.

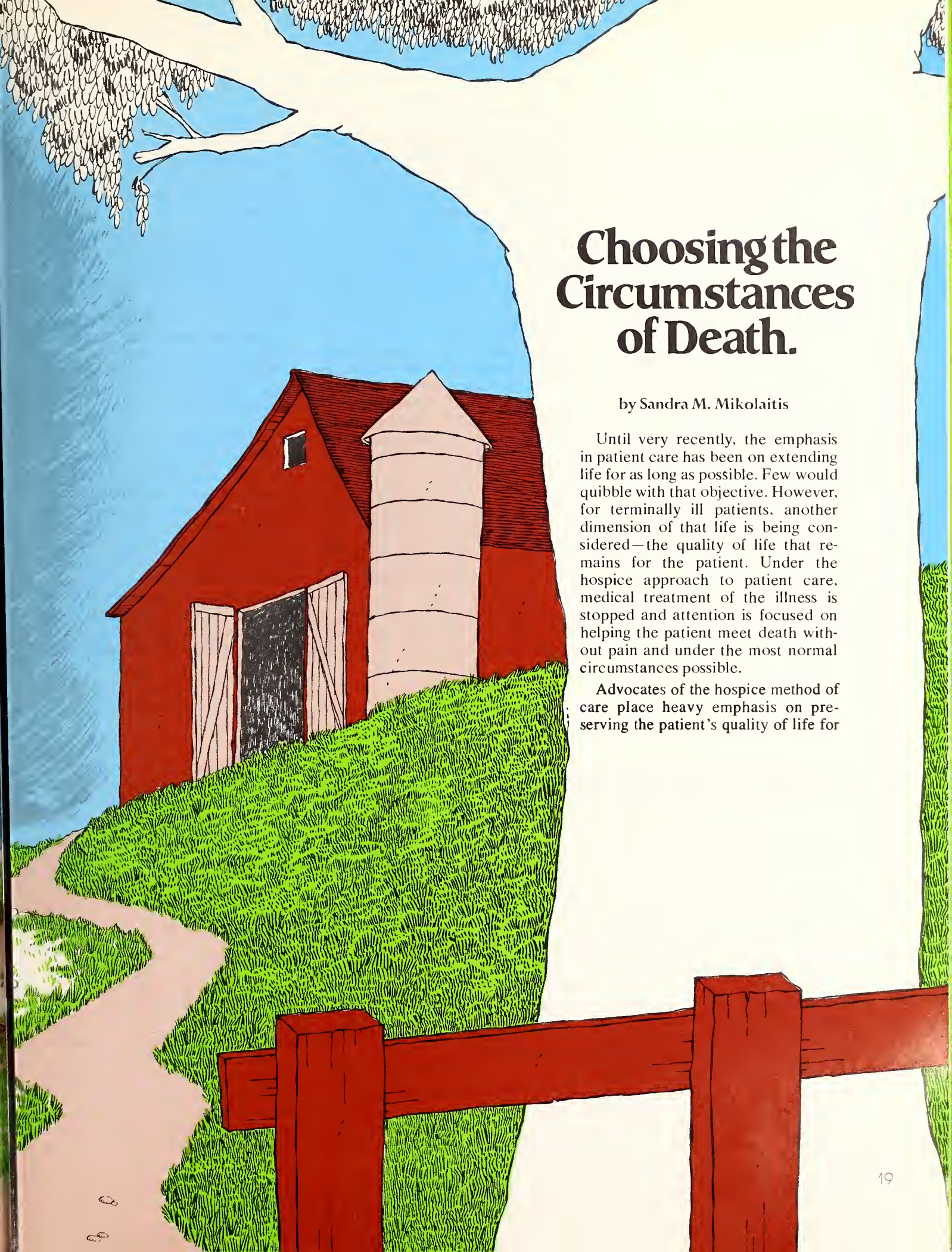
- Medicare regulations will be revised to encourage non-profit hospitals to pool their resources and share services ranging from basic medical programs to laundry services. As an incentive for cooperation, the hospitals will be allowed to retain a portion of the savings that result.

- Increasing the number of contracts subject to competitive bidding is expected to generate cost savings in the administration of Medicare. Although Congress delegated contracting authority to HEW in 1972, the department has not used this authority adequately in the past.

Commenting on the announcement by the Secretary, HCFA Administrator Robert A. Derzon said: These are important elements in the total HEW cost containment strategy and HCFA is wholeheartedly committed to these programs. Implementing these programs will mean an added responsibility for HCFA staff, but the results that we can achieve will be a source of pride. Certain of these measures, such as the second opinion, will improve medical care for our beneficiaries. Shared services in hospitals can improve quality, reduce price and tighten screening; competitive contracts enhance our management of program contractors.

Continued on page 29


HOSPITAL
HOSPICE



Choosing the Circumstances of Death.

by Sandra M. Mikolaitis

Until very recently, the emphasis in patient care has been on extending life for as long as possible. Few would quibble with that objective. However, for terminally ill patients, another dimension of that life is being considered—the quality of life that remains for the patient. Under the hospice approach to patient care, medical treatment of the illness is stopped and attention is focused on helping the patient meet death without pain and under the most normal circumstances possible.

Advocates of the hospice method of care place heavy emphasis on preserving the patient's quality of life for

the time that remains. They feel this approach is far more humane than the conventional treatment for a terminal illness, where the psychological needs of the patient are customarily left entirely to the patient's family.

Although few studies have been done on the quality of life under hospice care, one study of terminally ill cancer patients showed an overwhelming preference for the hospice type of treatment over the more traditional hospital-managed death. Of 73 patients studied, 38 in the care of Hospice Inc., in New Haven, Connecticut, had lower levels of anxiety, depression, and hostility in 20 of 23 categories measured. Hospice patients also were better adjusted to their dying than non-hospice patients.

Evolution of the hospice

The hospice, which dates back to medieval times as a place of rest and recovery for returning crusaders, was revived and medically updated during the 1960s. It was part of a greater search for quality of life and paralleled such concerns as conservation of the environment.

The most famous hospice, St. Christopher's, was founded in 1967 in London. And in 1974 its best-known prototype in the U.S., Hospice, Inc., became operational.

Today in the United States there are about 170 organizations studying the hospice concept, 25 of which operate hospice programs. Hospices were on the agenda of the American Medical Association's annual convention in June, and the California Medical Association is now drafting standards for hospice certification. The Health Care Financing Administration has announced that it will conduct research and demonstration projects which study the potential for Medicare and Medicaid coverage of hospice care.

Hospices differ in the way they provide care. Some offer only inpatient care; others specialize in home care with a few hospital beds as backup. Still others have both inpatient and home care. Regardless of the type of operation, hospices share many characteristics:

- They emphasize pain control rather than disease control.
- A physician provides medical direction.
- An interdisciplinary team composed of a physician, nurse, social worker, therapist and consultants provide services.
- Coverage is 24 hours, seven days a week, with emphasis on medical and nursing skills.
- Volunteers are an integral part of the health care team.
- Care of the family by the hospice staff extends after death through the period of bereavement.
- An autonomous hospice administrator coordinates the home care and inpatient programs.

Symptom control

The hospice approach follows the philosophy that pain, as experienced by most terminal patients, is nearly always manageable by drugs. Contrary to customary practices, drugs are taken regularly before the patient actually experiences pain. Says Dr. Robert N. Butler, director of the National Institute on Aging: "This differs from the currently fashionable PRN, or 'as necessary' regimen, where the patient is allowed to de-

A Dose of Reality*

To find out what happens when terminally ill patients are confronted with the reality of death, CBS' Morley Safer interviewed a nurse who has been doing just that for four years at a Pennsylvania hospital. The interview, aired recently on 60 Minutes, *has been adapted for the* Forum.

Morley Safer: A dose of reality is what we call this story. When we think of hospitals we think of life-saving places. They have a "Marcus Welby" image: the diagnosis will be right, the treatment will be correct and the patient will be cured. But there's another side to hospitals that the public, the nurses and the doctors would just as soon not dwell upon: hospitals are where most people go to die.

Death or the prospect of death is a symbol of medicine's failure to heal; and so while hospitals try to make the dying as physically comfortable as possible, they do not like to recognize that it is a person, a life, that's being lost. And thus the dying are, for the most part, ignored.

But within the last few years, some hospitals have begun to recognize the isolation of the terminally ill. One of them is the Harrisburg, Pennsylvania hospital where a young nurse was appointed to care for more than the physical part of dying. Each day she faces the cold reality of death. What she offers her patients is a warm dose of reality.

Joy Ufema: There's nothing wrong with the fact that every human being has to die. There is something wrong with how we do that, I believe. And so the warm dose of reality is I think human beings can take it.

Safer: Joy Ufema is like no other nurse you've ever met. At Harrisburg Hospital, while other nurses and doctors are preoccupied with saving patients' lives, she is preoccupied with preparing people for death. Death is the least considered part of living, and yet it is the one part of living that is common to everyone. So when Joy Ufema makes her rounds, she is aware of her own

velop pain, waits while it worsens (complaining is discouraged) and finally calls a nurse who administers the drug at her earliest convenience. By taking carefully titrated dosages before the pain begins it is possible to erase both the memory and fear of pain, thus enabling the patient to review his or her life in peace and come to terms with approaching death."

Once pain and other symptoms are brought under control the patient is more able to enjoy the period of life that remains. Patients are assisted by the hospice team to continue their work and family lives with minimal disruption.

Most hospices in the U.S. control pain with a mixture of morphine or methadone, codeine, alcohol, chloroform water, and syrup. Outside the U.S. heroin is sometimes substituted for morphine or methadone.

Types of service

Hospice care can be provided in many settings. In England, for instance, inpatient care is more prevalent than home care, although many of the English hospices have home care programs. But even though the emphasis is on institutional care, every effort is made to create a home-like atmosphere. Patients are encouraged to bring personal belongings to their rooms, such as a favorite piece of furniture and pictures. Liquor is served, families can spend the night, and visiting hours are extremely flexible.

The hospice experience developing in the United States departs from the English one in that emphasis is placed on home care for the terminally ill. Inpatient hospices in the United States are used mainly in three circumstances: (1) when there is no person in the patient's home to assist in the care of the patient; (2) when the patient's pain and symptoms must be closely monitored and (3) when the family needs rest from the physical and emotional stress which results from caring for the patient in the home.

Many advanced terminal patients prefer dying at home with family and friends. The hospice home care program offers physician care, specialized nursing services and other forms of assistance to enable the patient to remain at home as long as possible.

Hospice, Inc. reports that, while a national study shows that most people wish to die at home, only 10 percent do. By contrast, 33 percent of Hospice Inc.'s patients died at home during its first year of operation, 65 percent died at home during 1977, and in the first quarter of 1978, 71 percent of the patients died at home. Hospice, Inc. views the use of its inpatient facility, which will become operational in October 1979, as a necessary back-up, rather than a change in emphasis of care.

Hospice, Inc.'s success with its home care program is attributed to many factors, including an extensive overall medical management plan for each patient and highly individualized response to the patient's needs by its multi-disciplinary home care team. The team consists of three physicians, eight nurses (some of whom are part-time), a medical social worker, and consultant radiologists, psychiatrists, physical therapists and a clinical pharmacologist. A valuable part of the team is a corps of more than 50

---

mortality and of the part of dying that people fear more than death itself: abandonment, or maybe worse—the inability by those around them to recognize the inevitable.

Ufema: Sometimes we have to use pretty nitty-gritty terms.

Safer: Like?

Ufema: Like: What are your feelings about your funeral?

Safer: Martha Diller has leukemia. She has just been told by her doctor that there is little hope left.

Ufema: Do you have any preferences about your funeral? I see you have a faith; would you like a church funeral and special hymns and things? You seem to be a— a very warm, loving person, and I want to see some special things that would be part of you even in your passing.

Martha Diller: I really don't know. One of my best friends is our church organist, and she's taught my children in piano and organ. I couldn't ask her to play for my funeral.

Ufema: But maybe that's all she can give you, Martha.

Diller: She's the dearest person in the world.

Ufema: Maybe that's what she'd want to give you. A lovely tribute to you.

Diller: Yes, yes, but it's too much to ask one of your best friends to do something like that.

Ufema: Can you ask her and see?

Diller: I guess I could.

Ufema: Because what if you didn't ask her, Martha, and she said later, "That stinker never asked me to play at her funeral." Huh?

Diller: If it were her funeral I couldn't do it for her because I can't play.

Ufema: Oh, okay, okay.

Some days I say enough is enough, and I lock myself in the office and write letters and make phone calls because I can't— I can't watch another hurting person. If I'm with one human being for one week and help him to die his way, and fight for his right to do that—and juggle things so he can—then that's worth that whole week's work.

Safer: Do you help people to resist dying if they want to?

Ufema: Yes, if that's what they want.

trained volunteers.

Method of operation

Criteria for admission to Hospice, Inc. includes:

- A terminal disease with a prognosis of less than six months.
- A person available around-the-clock who will assume responsibility for the patient's care in the home.
- Location of the patient's home within the hospice's service area.

Once a patient is referred to the hospice, a member of the hospice team, usually a nurse, visits the patient and his family to assess their needs. The report includes how the patient and family are coping with the impending death, their anxieties and worries, the patient's physical condition and his symptoms, such as diarrhea, anorexia and insomnia, the patient's medication, and the nature and duration of pain.

Other visits may be made by members of the team to insure that a comprehensive assessment of the patient's condition is made. The team works in collaboration with the patient's physician.

After the complete medical evaluation, the patient is placed on drugs to control pain and the symptoms of the disease. Included in the patient's plan of care are such drugs as anti-emetics, anti-depressants, and steroids. The hospice team regularly monitors the patient's condition and the medication. The primary care nurse assigned to the patient closely monitors the effects of the drugs and keeps the physician and other members of the team informed daily of the patient's condition. According to Hospice, Inc., "visits by team members are viewed by the patient and family as far more than a check-up. They feel a visit is valuable because it is time spent with a person or persons who see patients as individuals facing great physical and emotional crises. The visit may provide supportive counseling; it may give guidance and instruction in self-help; or it may offer volunteer services to free the family to draw closer to the patient and themselves."

The social worker helps the patient and the family lead as full a social life as possible. Volunteers play an important role in helping the patient and family cope with anxiety and worry. They assist the patient with such daily tasks as shopping and transportation.

Bereavement program

It should be noted that hospices regard the patient and the family as a unit of care. The family is given a great deal of support to help cope with impending death. After the patient's death, bereavement visits are made to the family members, and, when necessary, the hospice team works with them and may even recommend other forms of psychological counseling.

The hospice's bereavement program is under the medical direction of the consultant psychiatrist and is supervised by the social worker. It usually begins with the primary care nurse on the case before death making the first visits to the family; care normally extends for a year. Volunteers are used extensively during the bereavement period, providing an outlet for the grief expressed by the family. The family is discharged from the program when the team deter-

---

I hope the guy who's been a fighter all his life and wants to die fighting has a chance to do it. If he wants to throw his water pitcher across the room and scream and shout and swear, that's his right, and I'm right there with him. That's his way of dying.

Safer: Joy sees herself as an advocate for the dying. The hospital pretty much goes along with her, assuming that she will exercise good judgment when she challenges some of the unwritten rules that are part of every big hospital. But some of the doctors still refuse to allow her to deal with their patients. If there are complaints from doctors about Joy's work, they go to Dr. Thomas Fletcher, medical director at Harrisburg. But under the terms of Joy's job, she does not report to Dr. Fletcher but is allowed to float freely and report directly to the very top brass.

Dr. Thomas Fletcher: Intially there was a lot of antagonism towards the possibility of a nurse coming between the doctor and the patient. But as time passed and better communication with the physicians evolved, this seems to be going down the drain a little bit. And the effect on the patients seems to be very definitely beneficial, especially on the relatives of the patients.

Safer: Joy, how popular are you with the doctors?

Ufema: I think it's fairly individual. I think over the four years I've had some successes with their patients, and I want to work mutually. We have had some altercations, and I believe we will probably always have some altercations.

Safer: Of what kind? What's the problem?

Ufema: Oh, it's usually over my presence in the room and the patient puts two and two together. I'm stimulating his thoughts, and opening the can of worms. The surgeon might say, I don't want you working with him. Yes, I understand that doctor, but it is true that the pancreas was full of disease and in fact probably he'll be obstructed soon. Well, sure, that's true. Yes, doctor, well, how long will this person live? Well, he's not going to live six months. I know, then let's be fair with him and discuss that.

There are physicians with whom I absolutely cannot communicate; they hang-up on the phone to me. They write blatant orders: "Death squad not to see this patient." And so I

mines that it is successfully coping with the bereavement.

Problems for hospices

Major problems encountered by hospices in the U.S. include certification and reimbursement by third-party payors. The Medicare and Medicaid programs do not currently recognize hospices, so to qualify for reimbursement under these programs, hospices must obtain certification as other types of health care providers. For instance, Hillhaven Hospice in Tucson has obtained certification as a skilled nursing facility; California's Hospice of Marin and the New Haven's Hospice, Inc. have obtained certification as home health agencies.

However, such certifications do not provide reimbursement for all services. For instance, in the case where a hospice is certified as a skilled nursing facility, no payment can be made for bereavement visits to the patient's family. In the case of a certified home health agency, drug costs are not reimbursed under the Medicare program. Hospices attempt to keep patients ambulatory; therefore, when a patient is no longer "home-bound," he can no longer use his Medicare home health benefits.

Another problem cited by organizations interested in establishing a hospice program is financing. This is due to the understandable reluctance to invest in a relatively new concept.

Hospice, Inc. estimates the average cost per patient during 1976 at $750. This cost included about 15 home visits made by the hospice team plus drugs. The average patient was under care for 3.1 months. Currently, the average cost of caring for a hospice patient is about $900. However, this figure does not cover the extent to which patients use services of other health care providers, such as hospitals, nursing homes and visiting nurse associations. The daily cost of an inpatient at Hospice, Inc. is projected to be less than $115.

The future

Secretary Joseph A. Califano, Jr., has formed a Hospice Task Force to evaluate the hospice as an alternative method of care for those terminally ill. Among the points to be studied are the cost of care, methods of reimbursement and quality control mechanisms. The report to the Secretary is scheduled to be made in August.

HCFA will be conducting research and demonstration projects for a variety of types of hospices to determine the levels of care provided in both home and institutional settings.

At the same time an interagency governmental committee, known as the Ad Hoc Committee on Pain and Discomfort, has been formed to promote research into better methods for the treatment of death, dying and chronic pain. Three subcommittees which will study terminal illness, pain, and drugs used to treat pain, will submit their reports to the chairman in August. Recommendations will be made later this year to President Carter's health advisor. ■

Sandra M. Mikolaitis is responsible for administering HCFA's hospice demonstration projects. She is a member of the Bar of the Commonwealth of Pennsylvania.

---

back off. At some point the patient's in the middle, and I'm not interested in a custody fight at his expense. It's just not the time and place, and so I back off. But it varies. One time I had a very good relationship with a patient. The oncologist called me and requested that I no longer see her, and I said I can't do that. I have a relationship with her. I'm helpful to her. I have a sense of responsibility and a willingness to risk quite a bit for that patient's right.

Safer: So what do you do? Do you simply run roughshod over the—the doctor, the patient's family and the hospital rules? What do you do?

Ufema: Sometimes I run roughshod. It depends on the physician. I don't blatantly go around breaking rules, but I certainly feel that we can bend easily. You know, some of the unwritten rules are so archaic. It's things like asking a little fellow who has leukemia on the pediatric floor if he'd like a couple of kittens to come and visit him, and he says yes. Well, the problem is solved. There's no one else with whom to confer. It's actually between him and the kittens, isn't it? And in a sense even five year olds get some control over the remainder of their lives.

I had a woman who had cancer of the trachea and was dying. I enjoyed getting her husband, who was also a patient in the hospital, into her room so that they shared some time together. She slept all night without a sleeping pill or hypodermic.

Safer: Is there a right way and a wrong way to tell someone they're dying?

Ufema: I guess I don't believe in actually telling a human being they're dying. I think if we listen well, they tell us.

Safer: What you're saying in a way I suppose is that the person knows or strongly suspects he is dying, and your presence confirms his worst fears.

Ufema: Yes. I get to be known as the death and dying nurse. It isn't that as I come swooping into the room they feel the harbinger of death has arrived. I feel—and I strongly believe—that they're grateful for someone who is willing to finally listen, to finally ask the right questions and explore their value as a human being. And that this passing has meaning to me.

Safer: This is a job the physician really doesn't want to do anyway.

Publications and Films

Please address all inquiries and requests for publications and films to the addresses in the listings. Items for review should be sent to Theresa Williams in care of this magazine.

You Can Save a Life. Bradley Smith and Gus Stevens, Simon and Schuster Bldg., Rockefeller Center, 1230 Avenue of Americas, New York 10020. $8.95.

This book contains step-by-step procedures on how to help people who are choking, drowning, in shock, poisoned, overdosed with drugs or are victims of serious accidents.

Approved Drug Products. (FDA #BD-78-100). National Technical Information Service, 5285 Port Royal Rd., Springfield, Va. 22161.

A 350-page catalogue of all the drugs the FDA has approved for marketing. The book is arranged by generic and brand name as well as by therapeutic category.

Dr. Fletcher: That's exactly right. The physicians in certain cases will do it, but physicians can be as uncomfortable in dealing with death and dying as a lot of other people are. And since it is an indication that maybe they've lost the ball game, it is something they'd rather avoid in certain cases.

Safer: Toni Dahlgren is 32 years old. She has two children—Sandy, who is seven, and 10-year-old Steven. Just over a year ago, Toni's husband Lonnie, who was only 34, died of a rare form of cancer. But for four months before his death, he knew and Toni knew that he was dying. He spent those last four months of his life at home. The most difficult part for both of them was how to tell the children, then only five and eight, that their father was soon to die. A friend told Toni about Joy, who came to visit and brought along a child psychologist. They told her to be honest, to tell the children the truth.

Toni Dahlgren: I asked Joy, "When should I tell the children that their father's dying?" And she said, "You'll know when, because they'll ask you." And they did. And my son asked me, "When is Daddy going to get well, in a couple of years?" It was obvious that Daddy wasn't getting well, and that he was so terribly ill he wasn't going to get well soon.

I said what Joy had helped me work out: "Sometimes doctors can't make people well." "Well, is Daddy going to die?" "Yes, Steven, I think Daddy is going to die." Now he asked me two questions which told me that he had thought this out in detail. He asked me, "Are you going to marry again?" And he asked me, "Are we going to move?" Then I knew that if I hadn't been honest with him, I would never have known what was on his mind, and he wouldn't have been free to talk to me. As it was, we were able to talk honestly throughout this period.

Safer: How important was Joy to you at that time?

Dehlgren: Joy was so utterly available to me. She told me that, even though my husband was helpless in bed, to let him make as many decisions as he could and give him as much control over his life as possible. And that's something I probably wouldn't have thought of by myself. I think people who came to visit us were surprised that the atmosphere wasn't one of utter gloom. Yes, we were suffering, but we were still a family and we were doing this last thing together as well as we could.

Safer: One of the things you're doing in a way is getting death out of the closet. But isn't there a case for keeping it in the closet—only to the extent that, by not thinking about dying, we live that much better?

Ufema: No. If I don't think about my death that's coming up, I don't put life into perspective. Perhaps that's my plea—for us to live life our own way before it's too late.

Diller: I guess the hardest part is telling my family. But I guess the one it's going to be the hardest to tell is Leslie. She's a junior in college this year.

Safer: For Martha Diller, there is little more that the hospital can do. She is being sent home where her husband and her children will look after her. They know just how sick she is. They, too, were prepared by Joy. It is no easy matter, but each of them can deal with the reality of their situation; each of them can look one another in the eye.

Diller: I'm feeling great right now.

Leslie: I think it's really good for the family to know the truth. It's hard but we can prepare ourselves for the worst. I can see now that she looks great, though I don't know why. I think it's easier to take if we prepare ourselves for the worst; our belief in God has really strengthened us.

Ufema: Leslie, will the family try to squeeze in some more living as fast as you can?

Mr. Diller: We probably will, yes. And we'll try to make it as comfortable as we can for each other.

Ufema: Doing more things together as a family?

Mr. Diller: Right.

Ufema: Good. Thanks very much. An aide will help you out.

Diller: Okay, thanks.

Ufema: I'm sorry this is happening.

Diller: God works in mysterious ways.

Ufema: I know He does. I don't like it.

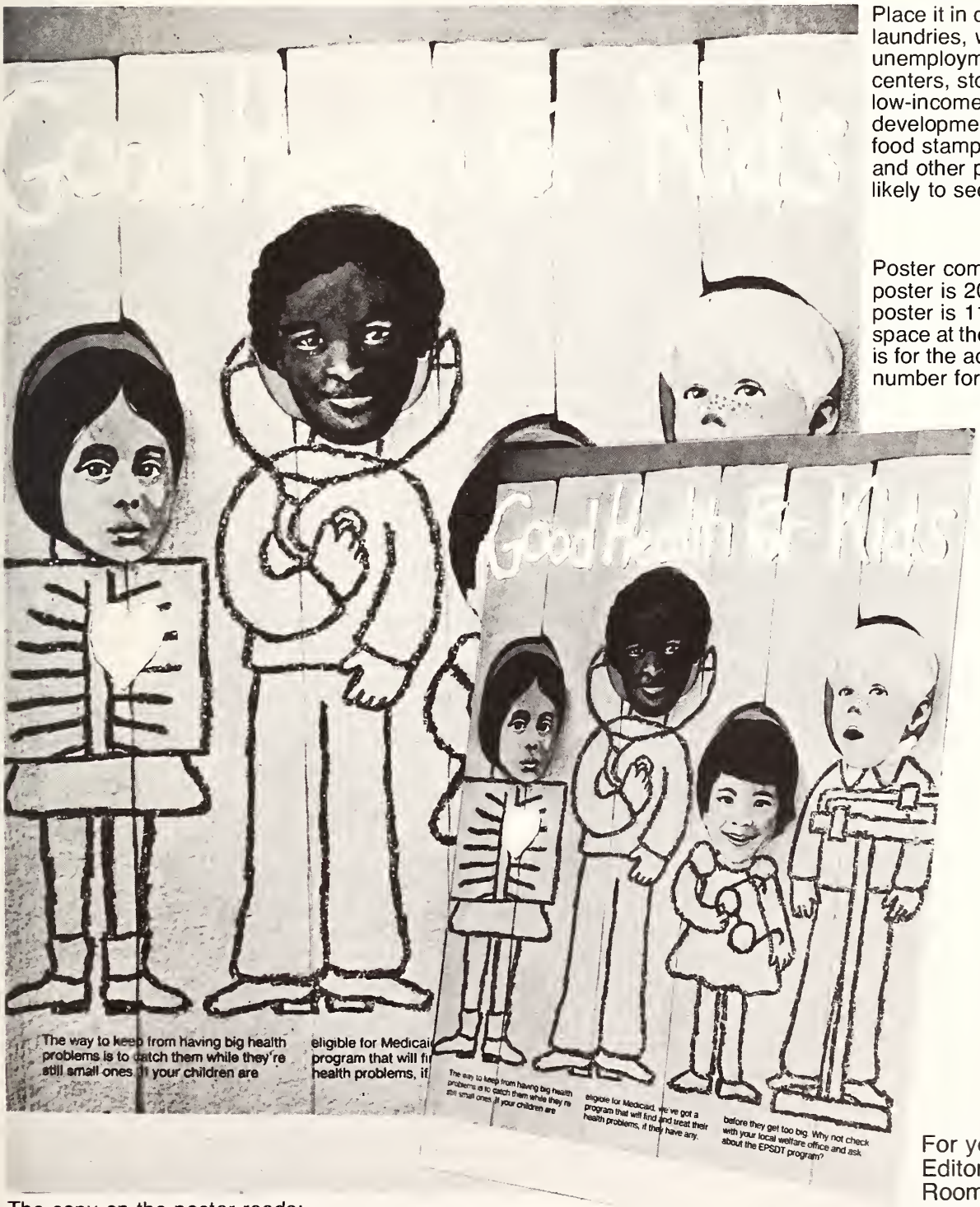
Diller: No, I don't feel that way. This is His will, this is for me.

Ufema: You're an inspiration. ■

Since this interview Martha Diller died.

FREE!

For all state and local agencies and volunteer organizations. Eye-catching, full-color posters to publicize the Early and Periodic Screening, Diagnosis and Treatment Program.



Place it in churches, self-service laundries, welfare offices, unemployment offices, day care centers, store fronts, low-income housing developments, supermarkets, food stamp distribution centers and other places parents are likely to see them.

Poster comes in two sizes. Wall poster is 20″ x 23″. Standup poster is 11″ x 14″. Blank space at the bottom of the poster is for the address and telephone number for local information.

For your supply, write:
Editor,
Room 5327 MES Building,

Washington, D.C. 20201

The copy on the poster reads:

The way to keep from having big health problems is to catch them while they're still small ones. If your children are eligible for Medicaid, we've got a program that will find and treat their health problems, if they have any, before they get too big. Why not check with your local welfare office and ask about the EPSDT program?

Increasing Federal Communication with Beneficiaries.

by Virginia Douglas

HCFA officials in the 10 federal regions who usually spend their days coping with administrative problems, have in the past year added a new dimension to their jobs and to their understanding of the myriad problems of Medicare and Medicaid beneficiaries.

As one regional administrator put it, "The programs we deal with daily have been humanized because we have gained a greater understanding of the individual problems of beneficiaries." A result of tightening the connection between the federal officials and beneficiaries was that the officials and their staffs were able to solve some problems on their first contact with beneficiaries, clear up misunderstandings about the Medicare and Medicaid programs, and improve services to beneficiaries.

This new approach was conceived by HCFA Administrator Robert A. Derzon who was concerned that decisions would be made on the numbers contained in issues alone without factoring in the human effects of the programs. The efforts to better understand beneficiaries' problems have included: public forums, toll-free information numbers, and visits to nursing homes and other providers of services.

Open forums

One of the best ways to reach HCFA's constituency is through public forums to which Medicaid and Medicare beneficiaries and other interested persons are invited. By holding such meetings at the local level, people from all economic levels can be heard. Beneficiaries are encouraged to discuss problems and concerns at the programs, and to make suggestions for improvements.

After holding several regional forums, HEW staff members confess that confronting flesh-and-blood poverty-stricken people, the aged and the disabled, adds another dimension to the job of administering the program at levels several times removed. Example: an elderly man rose at a Medicare forum and sternly informed officials that, because Medicare refuses to pay for eyeglasses he needs, he is in serious danger of falling and suffering a broken hip. Such an injury he said, would cost Medicare many times the cost of the glasses. He was told that Medicare does not pay for glasses and other medical expenses because legislation was written to cover major expenses, such as hospitalization. Congress felt that small expenses could be paid for out of the individual's budget.

In the Atlanta region, public forums have already been held in Gulfport, Mississippi, and West Palm Beach, Florida. Other meetings are scheduled this year for Bowling Green, Kentucky, and Jackson, Tennessee.

Some 350 Gulfport residents met early this year at a community center to air their concerns about Medicaid and Medicare to federal and state administrators.

Beneficiaries were invited through local senior citizen groups, welfare offices and community action agencies.

The most frequently voiced concerns at the forum were about lack of coverage. Those at the forum also

Virginia Douglas is a staff editor in HCFA's Office of Public Affairs.

wanted to know why Medicare and Medicaid rules couldn't be written in plain English and why every increase in Social Security benefits was followed by an increase in Medicare premiums. In addition, they complained about the refusal of most Gulfport area doctors to accept Medicaid patients.

Responding to the beneficiaries' questions were members of a panel that included the HCFA Regional Administrator, representatives from the state medical commission, the Medicare carrier and the Medicaid fiscal agent. The panel was able to answer most questions and helped resolve problems caused by misunderstandings.

In the afternoon, physicians and representatives from hospitals, nursing homes and other health care providers confronted state and federal officials with their problems. Among the problems was lack of coverage for services they felt to be of paramount importance to the health of their patients, especially dental care and home health care. Reimbursement rates were also challenged as being too low and payment too slow. Program administrators explained the limitations of law and regulations, but also noted these issues as input to improving procedures and modifying policies to rectify problems.

An immediate result of the Gulfport forum was the establishment of a series of workshops by the regional office to train beneficiaries as volunteers. The volunteers help at hospitals and community centers by informing fellow beneficiaries about coverage under the programs and assisting with paperwork.

Across the continent, 200 representatives from 70 senior citizen organizations and agencies in a four-state region met for two days in Seattle to receive information on Medicare eligibility and the extent of coverage the program offers.

The conference began with a series of small workshops, each with about 20 participants, followed by a general meeting featuring a panel of experts which answered questions from the floor. Two local TV stations used the conference as a basis for programs on Medicare and Medicaid, vastly expanding the dissemination of information.

The enthusiastic endorsement of those attending the conference resulted in: training of persons to provide information and assistance to beneficiaries, such as community action and community service workers, and nursing home and hospital staff and volunteers; provision of a slide and tape program on Medicare for presentation to groups; and publication of a newsletter for beneficiaries. The conference also generated continuing requests for speakers and participants for such major meetings as the Idaho Conference on Aging and produced useful contact with many beneficiary groups.

Aides assist beneficiaries

Many states and localities use aides to answer questions for Medicare beneficiaries and help them complete forms.

Sometimes such assistance is provided at senior centers or public places where many elderly persons are found, such as shopping centers, congregate meal sites, Farm Bureau Federation offices and senior day care centers. But most often such aides work in hospitals where they are able to offer consolation and friendship as well as information when the beneficiary faces hospitalization. Some are volunteers; others receive nominal pay.

At the Paul Kimball Hospital in Lakewood, New Jersey, volunteers visit Medicare patients in their rooms, giving them a copy of the latest Medicare booklet and answering questions. Initially, volunteers were trained by the Medicare regional office and the Medicare carrier, under sponsorship of the Ocean County Office on Aging. The project proved so effective that the hospital has continued it and now sends volunteers in to the community.

Missourians seeking Medicare benefits can question employees in offices of the Farm Bureau Federation throughout the state. The HCFA regional office in Kansas City trained staff members of the federation.

Some 130 senior citizens in Texas have been trained to help their peers with Medicare and Medicaid problems by answering claims questions and preparing forms. Conducting the training, along with the federal staff and the state Medicaid agency, were local units of the American Association of Retired Persons and Texas Blue Cross and Blue Shield Associations.

While results of aide programs are difficult to document or measure, regional directors are convinced that aides provide meaningful help to Medicare beneficiaries, as well as a sympathetic, personalized approach that helps humanize the program. Federal staffers periodically check the volunteer and paid aide programs to be sure they are still needed and operating as planned. Follow-up training sessions are held when necessary.

To more precisely measure the effectiveness of an aide program in Indiana, in terms of numbers of volunteers used and beneficiaries served, the regional office is discussing a method of auditing claims to document its effectiveness. Currently, aides complete a report on each person counseled and submit them weekly to the regional office for evaluation.

The result of the audit is expected to be a valuable tool to finetuning the volunteer effort.

New England regional officials are preparing a questionnaire for hospital administrators, patients and volunteers. The staff feels that the results of this analysis will confirm their subjective impression that the program is highly successful in reaching beneficiaries who might otherwise have unresolved questions and problems relating to Medicare.

Newsletters

The Atlanta regional office writes a

monthly column on Medicare and Medicaid for a newsletter published by the State of Florida. The *Senior Consumer Newsletter* is distributed free to some 70,000 elderly persons. Each column begins with specific aspects of the programs and ends with an invitation for questions to be sent directly to the regional office. If the questions are broadly applicable, they are often answered in the column.

Seattle HCFA officials distribute a newsletter, *Medicare and You*, through beneficiary organizations, social security offices and other agencies serving the elderly. Topics covered also include Medicaid and issues relating to program quality and fraud and abuse. The regional office lends a slide and tape presentation on Medicare to organizations of beneficiaries upon request.

Visiting beneficiaries

Various components in HCFA regional offices seek greater understanding of beneficiaries' problems through direct contact with them. For instance, the health standards and quality staff of the Atlanta office recently visited an Augusta, Georgia nursing home and interviewed residents covered by Medicaid or Medicare.

The staff found that some residents were not aware of alternative kinds of care, such as household aide services and home health care. Several residents complained about being "dumped" in the nursing home after being sent from one state mental institution to another. Federal staff members were able to resolve some of these problems.

Another part of the Atlanta regional office monitors health care providers who are reimbursed directly by Medicare. These staff members have visited a large number of hospitals, skilled nursing facilities, home health agencies, comprehensive health centers and other health facilities since November 1977 to observe services to beneficiaries and how providers of services deal with patients. In general, attitudes toward beneficiaries were found to be positive. Had it been otherwise, corrective action would have been taken.

Telephone inquiry services

At least four regions have initiated toll-free telephone service to Medicare carriers that provides quick answers to questions on coverage and claims processing.

As part of an experimental project, the toll-free telephone number of the Arkansas Blue Cross/Blue Shield Association is printed on the Medicare explanation of benefits form with the suggestion to dial the number if assistance is required.

During a five-month test period last year, 5,642 calls were received. Of these, 88 percent related to medical insurance claims; the remainder concerned hospital insurance, Medipak (the private Blue Cross/Blue Shield plan for people over 65) and Civilian Health and Medical Programs of the Uniformed Services. Most calls were answered immediately by service representatives with only a few requiring research and a call-back or letter.

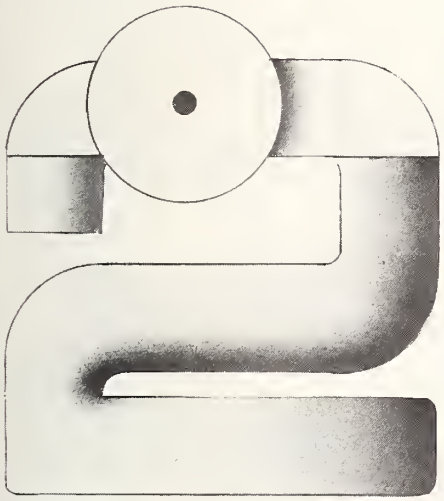
A random sample of persons using the service showed overwhelming satisfaction with it. The only complaint: the lines were often busy. The toll-free number is now a permanant feature of the carrier's program. Similar lines are planned for other states in the region by year's end.

Iowa's toll-free telephone service for Medicare beneficiaries, inaugurated on May 1, was publicized in newspaper articles and notices included with the explanation of benefits forms mailed to Medicare beneficiaries. By June calls were averaging 180 per day. A similar service in seven New York counties at first showed a disappointing volume of calls—only eight per day. But when the Medicare carrier included notice of the service with its explanation of benefits form, the volume picked up to about 75 calls per day. The service has been extended to all counties in the state.

In Washington, a direct phone line to the Medicare carrier has been installed in the main social security office. Beneficiaries who come to the office can contact the carrier directly, easing the burden on social security personnel. ■

State and National News

Continued from page 17



Second opinion for surgery encouraged by HCFA.

In an effort to reduce the costs of health care, HCFA will help pay for second opinions sought by Medicare and Medicaid patients for elective surgery.

Payment will be on the same basis as the first opinion, with HCFA paying 80 percent of reasonable costs for beneficiaries enrolled in Medicare Part B. Most states will pay all reasonable fees for Medicaid beneficiaries who seek a second opinion.

The Second Opinion Program is intended to aid patients in making an informed decision about their proposed surgery. "It isn't meant to tell anyone they can't have surgery," says HCFA Administrator, Robert A. Derzon. "That decision is up to the patient. What we want people to do is get all the information they can get before making their decision. We want them to know the risks and benefits of having surgery. For this, two physicians are sometimes better than one."

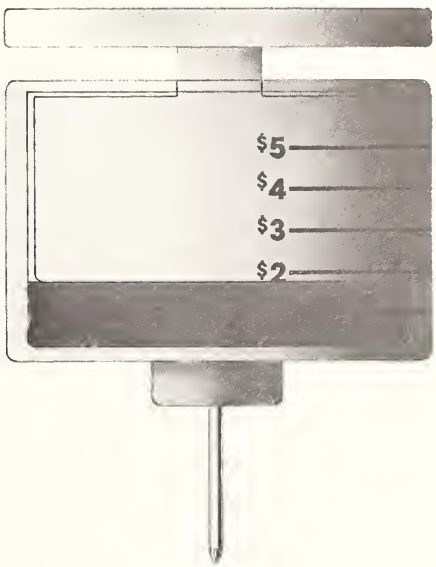
Patients may select a second physician themselves or ask their physician for a recommendation. HEW is establishing local referral centers across the nation which will supply names of physicians who will give a second opinion. The physicians will be board certified whenever possible. These names will come from lists of medical doctors and doctors of osteopathy who have agreed to render second opinions. The centers will note which physicians accept Medicare or Medicaid payments, but will not make appointments for patients.

Any Medicare beneficiary who decides to undergo surgery—no matter what the second physician's opinion—will be covered by Medicare. Most states support this program under Medicaid.

Malpractice insurance for consultant pharmacists

Malpractice insurance is now offered by the American Society of Consultant Pharmacists to cover consultants who specialize in serving institutionalized elderly patients. The insurance was developed due to the lack of appropriate coverage offered by commercial insurers.

Dr. Herbert Pardes was appointed director of the National Institute of Mental Health. He formerly was head of the Department of Psychiatry at the University of Colorado Medical Center.



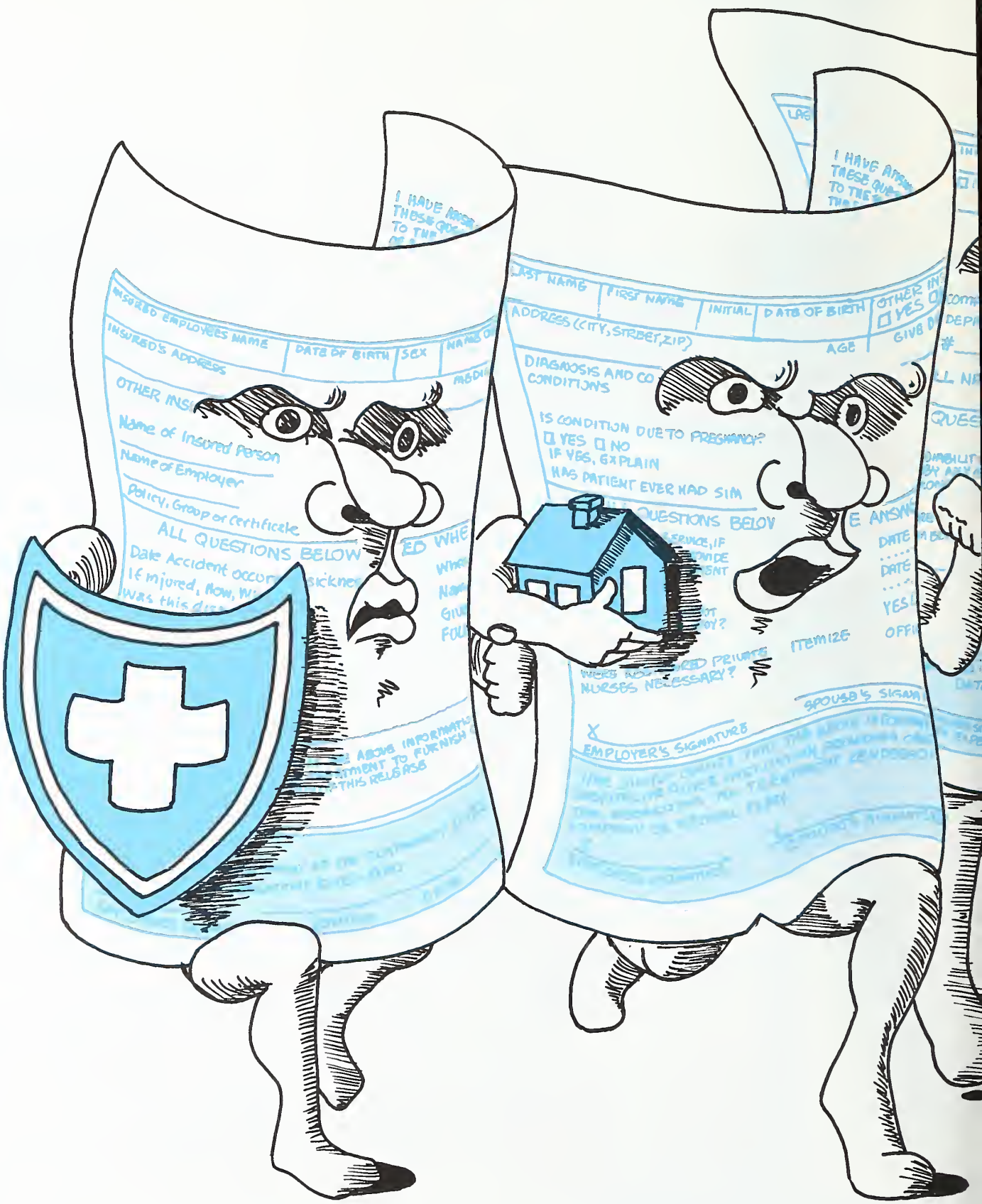
Survey shows MDs vague on hospital costs.

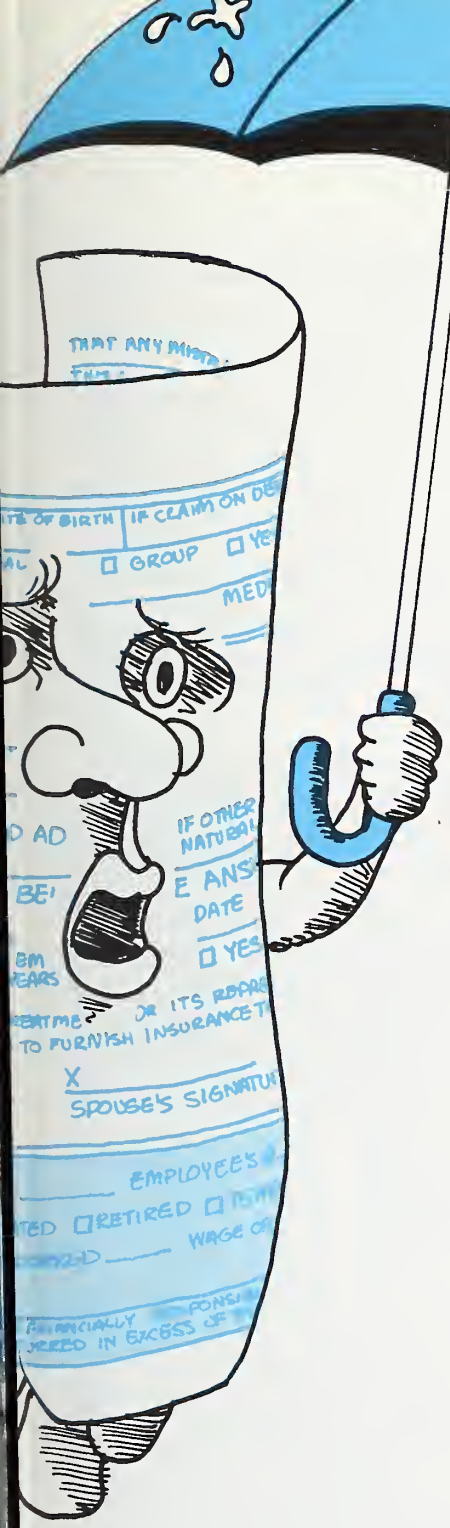
Most students and members of the clinical faculty housestaff of the University of Miami School of Medicine were found to be unaware of common hospital care costs, according to a recent survey.

The findings by Drs. Stephan J. Dresnick and William Roth, two resident physicians, showed the housestaff scored only three out of 17 answers correct, with the faculty scoring only 3.6 out of 17. Answers falling within plus or minus 10 percent of the cost of a service were judged correct.

Analysis of the survey showed students and physicians were most familiar with the costs of chest x-rays, room rates and electrocardiograms. They were less familiar with the prices of blood transfusions and intermittent positive breathing treatment.

The survey resulted in a cost containment campaign at the university's teaching hospital. ■


INSURED EMPLOYEES NAME
DATE OF BIRTH
SEX
INSURED'S ADDRESS
Name of Insured Person
Name of Employer
Policy, Group or Certificate
ALL QUESTIONS BELOW
LAST NAME
FIRST NAME
INITIAL
DATE OF BIRTH
ADDRESS (CITY, STREET, ZIP)
AGE
DIAGNOSIS AND CO
CONDITIONS
IS CONDITION DUE TO PREGNANCY?
YES NO
IF YES, EXPLAIN
HAS PATIENT EVER HAD SIM
QUESTIONS BELOV
ITEMIZE
NURSES NECESSARY?
EMPLOYER'S SIGNATURE



Competition in the Health Care Industry

As with most gatherings of economists and social scientists, no unanimity was reached about what public policy toward health care should be. Indeed, the conference highlighted how little we know about the proper doses of competition that might be injected into this industry.

More than 600 persons representing a variety of viewpoints on competition in the health care field gathered in Washington at a conference on competition sponsored by the Federal Trade Commission's Bureau of Economics. The following is a summary of the recently published report by the Bureau.

by Dr. Warren Greenberg

Four major findings on competition in the health care field evolved at the Federal Trade Commission conference. They are:

- Competition does exist in the health care sector, but it is not necessarily the type of competition that exists in other industries nor is it helpful in restraining monopoly power. For example, competition may take the form of new, and perhaps better, equipment and technical apparatus without regard to cost considerations. Competition which tends to control the cost of medical care is not as apparent but it did exist once in the State of Oregon among health insurers and might exist between HMOs and the fee-for-service sector.
- There are several reasons for atypical competition in the health care industry. Among them are the pervasive influence of Government, the special role of the physician, and other peculiar characteristics of the industry. The last two characteristics include the lack of information from providers and insurance companies which reduces prices to consumers of health care services. Finally, the uncertainty surrounding medical care is so great that physicians themselves are often unsure of the outcome of treatment.
- Although the health care industry may not conform to the economist's ideal of competitive behavior, there were no clear answers as to the most appropriate form public policy should take. However, most observers believe that, even in view of the health industry's special characteristics, antitrust laws have at least some place in public policy. At the same time most believed that current public policy, with its emphasis on regulation, is not working optimally and the desired amount of Government intervention has not yet been found.
- Finally, there was a strong consensus that more research is needed on competition in health care. Most papers reflect the lack of empirical study of the industry.

In his opening remarks FTC Chairman Michael Pertschuk stressed the importance of the health care industry, but acknowledged that the costs of health care are constraints of which we should be cognizant. Pertschuk suggested that health care can be classified as a business, but, nevertheless, he emphasized that the concept of competition in health care must be "responsibly explored" by the FTC.

Dr. Theodore Cooper, former Assistant Secretary for Health and current Dean of the Medical College at Cornell University, agrees that economic factors are important in health policy deliberations. Dr. Cooper notes, however, that the FTC's emphasis on competition in the medical marketplace is at variance with that of Congress and the Administration. He asserts that competition does exist in the health care sector—such as competition for patient referrals—but concedes that it differs from the price competition usually envisioned by economists.

A central tenet of economic theory is that resources which produce goods and services will flow to endeavors where the highest returns can be captured. All other factors held constant, an increase or decrease in the supply of goods or services will cause a decrease or increase in the price of the goods or services. In contrast, all things held constant, an increase or decrease in the demand for goods or services will increase or decrease the price of goods or services.

These basic laws of supply and demand traditionally have such powerful predictive power that many economists believe their theoretical framework can be applied to any industry in the economy. But is the medical care industry or health care sector different? Are there market imperfections which inhibit the laws of supply and demand from operating and which make the economists' goal of an optimal use of resources impossible? If there are such restrictions,

Competition does exist in the health care sector—such as competition for patient referrals—but it differs from the price competition usually envisioned by economists. Theodore Cooper.

Complex socioeconomic variables associated with the conduct of physicians make it difficult to isolate monopoly power even if significant correlations can be found between physician populations and per capita utilization. Donald Yett.

Dr. Warren Greenberg is a staff economist of the Federal Trade Commission's Bureau of Economics. A copy of the complete proceedings, Competition in the Health Care Sector: Past, Present, and Future, is available from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

public policy, which has a pro-competitive bias, may be inappropriate for segments of the medical sector.

Mark Pauly, professor of economics, Northwestern University, answers yes, no and maybe to the question "Is medical care different?" depending on the extent of consumer experience with an illness and the type and scope of the individual's medical care contacts with physicians. It is the absence of information on the appropriate price-quality level that is the most important potential difference between medical care and other services.

Burton Weisbrod, professor, Institute for Research on Poverty, University of Wisconsin, suggests that the usual efficiency criteria employed by economists are not necessarily adequate for the health industry. In his view, health and medical care may be different because of the public's concern with access (not usually considered by economists) rather than an efficient allocation of resources. Further Weisbrod contends that the difficulties inherent in evaluating medical services should help to caution public policymakers that any goal of stimulating competition through more information should include both price and quality data to consumers.

Areas of competition

The lack of information is stressed again in the paper "Competition among Physicians" by Frank Sloan, professor of economics, Vanderbilt University and Roger Feldman, professor of economics, University of North Carolina. They devote a considerable portion of the paper to analyzing the extent to which physicians can create their own demand.

Although any ability of physicians to create their own demand must take into account a reduced net price that patients pay in the presence of insurance coverage, surely some of this alleged creation in noncovered physician services must be due, in part, to consumer ignorance.

Sloan and Feldman use standard economic analysis—the neoclassical framework—to evaluate previous economic literature on the ability of physicians to create demand. Although they conclude there is some empirical evidence to suggest that physicians can create demand, many additional variables which can help to test the hypothesis are still unaccounted for in order to make a definitive judgment.

The authors point to elements in the market for physicians' services that, in their opinion, might be deemed monopolistic. Advertising prohibitions have made comparison shopping difficult for the consumer and may contribute to a wide variation of physician fees and consequent monopoly power.

The role of the medical society's relationship with Blue Shield is suspect, whereas physician-promulgated relative value scales are found to be relatively innocuous. Finally, Sloan and Feldman comment on restrictions and licensing requirements of non-physician providers, suggesting that they "often appear to serve the financial interest of physicians."

Uwe Reinhardt, professor of economics, Princeton University, devotes most of his comments to the methodology, assumptions, and conclusions of the Sloan-Feldman exposition of the controversy about physician-induced demand. Even the most sophisticated economics statistics may not be able to demonstrate that physicians can create their own demand since these relationships are clouded by the physician's ability to order ancillary services and diagnostic tests. Finally, questioning whether econometrics will ever settle the issue of physician-induced demand, Reinhardt concludes that "tracer analysis," which evaluates the entire treatment of various conditions under various alternatives, may be the best solution.

Donald Yett, professor of economics, University of Southern California, like Reinhardt, focuses on the Sloan-Feldman view that a physician is able to create his own demand. Yett believes that complex socioeconomic variables associated with the conduct of physicians make it difficult to isolate monopoly power even if significant correlations can be found between physician populations and per capita utilization. Indeed, Yett is inclined to question all of Sloan and

It is the absence of information on the appropriate price-quality level that is the most important potential difference between medical care and other services. Mark Pauly.

Stress on price-oriented competition may pose problems for maintaining a given level of quality care. John Rafferty.

Advertising prohibitions have made comparison shopping difficult and may contribute to a wide variation of physician fees and consequent monopoly power. Frank Sloan and Roger Feldman.

Because Blue Cross and Blue Shield are beholden to hospital and physician providers, there are incentives for them to sell a more complete version of insurance than the commercial carriers. H.E. Frech and Paul Ginsburg.

Feldman's empirical evidence which points to monopoly power by the physician.

David Salkever, professor, Department of Health Care Organization, Johns Hopkins University, concludes that competition does exist in the hospital market but is "based primarily upon the availability and sophistication of services and facilities." Since this type of competition tends to raise rather than lower prices, modifications in insurance arrangements, the financing mechanism that accounts for more than 90 percent of expenditures on hospital services, must be made in order to move toward a semblance of price competition.

Salkever cautions, however, that even with a change in the amounts and types of insurance, the role of the physician in admitting patients and the high degree of hospital concentration found in many local markets may still impede price competition.

John Rafferty, senior research manager of HEW's National Center for Health Services Research, endorses Salkever's view that a focus on insurance mechanisms for hospital reimbursement is most important for understanding competition among hospitals. But Rafferty warns that a stress on price-oriented competition may pose problems for maintaining a given level of quality.

Insurance and alternative delivery

When examining the performance of firms in an industry, most economists focus on the rates of return and output of the leading firms. Typically, the firms that are studied are those which have profit-maximizing incentives. In their paper, H.E. Frech, professor of economics, University of California, and Paul Ginsburg, professor, Institute of Policy Science and Public Affairs, Duke University, analyze the not-for-profit firms.

They find that Blue Cross, because of its exemption from property and premium taxes in some states and its exemption from required reserves and other regulatory requirements, has developed "administrative slack" in the operation of their plans. Furthermore, they say that because Blue Cross and Blue Shield are beholden to hospital and physician providers, there are incentives for them to sell a more complete version of insurance than the commercial carriers.

The effect of Blue Cross in the health insurance market is to raise hospital prices rather than control costs. Rising prices for hospital services are of serious concern and government policy makers should consider a removal of the advantages Blue Cross enjoys vis-a-vis the commercial insurers, according to Frech and Ginsburg.

Not surprisingly, David Robbins of the Health Insurance Association of America, commends the Frech-Ginsburg analysis since their proposals call for Blue Cross to compete on an equal footing with the commercial insurers.

Robbins suggests, however, that the Frech-Ginsburg paper leaves out a significant explanation of the market power of Blue Cross: the lower prices that Blue Cross negotiates with hospitals for services compared to the prices obtained by the commercial insurers.

Administrative slack or inefficiency, that Frech and Ginsburg say exists in the Blue Cross Association, is disputed by Howard Berman, vice president of the American Hospital Association and former vice president of the Blue Cross Association. Berman cites a 1975 General Accounting Office analysis which shows that commercial insurers are less efficient than Blue Cross and a March 1976 *Social Security Bulletin* article which suggests that Blue Cross has the lowest ratio of operating expense compared with premium income of all insurers.

Insurance reduces the net price of services to the consumer. Assuming the usual downward sloping demand curve, more services will be demanded in the presence of insurance than without insurance. In addition, more services will be demanded at each of many possible prices, which shifts the entire demand curve and raises prices of services.

Joseph Newhouse, senior staff economist, Rand Corporation, con-

centrates on another effect of insurance, that of induced technological change, which tends to increase the rate of insured medical care expenditures relative to expenditures of uninsured medical goods and services.

Newhouse says his results are consistent with the view that a competitive model has been eroded for hospital services which are heavily covered by insurance compared to physician, dental, and drug services less heavily covered. Therefore, Newhouse expects that hospital prices and expenditures could continue to increase at above average rates for a long period of time.

Lawrence Goldberg and Warren Greenberg examine competition that existed in the 1930s among for-profit insurers in the state of Oregon before a physician-sponsored health insurance plan entered the market. This form of competition was based on cost control efforts where insurance firms questioned the procedures and methods of physicians. They suggest that the emergence of a physician-sponsored health insurance plan, the Oregon Physicians' Service, put an end to competitive cost control efforts by the private for-profit insurers.

The paper, "Competition of Alternative Delivery Systems," provides examples of how HMOs might compete and illustrates types of competition among alternative delivery systems. Alain Enthoven, professor of public and private management at Stanford University, suggests that competitive imperfections in the health industry are such that "simple generalizations" about the competitive impact of HMOs are "almost impossible to sustain."

Enthoven suggests that HMOs be put on an equal footing with the fee-for-service sector and eliminate "the subsidy of more costly systems of care through Medicaid/Medicare and the tax laws." In general, he believes that the market ought to be unhampered by government to encourage a fair market test between the fee-for-service sector and alternative delivery systems.

In reviewing the Goldberg-Greenberg and the Enthoven papers, Stuart Schweitzer cites the economic theory known as the "Theory of the Second Best." He cautions that injecting doses of competition in only sections of the complex health care industry might not lead to more efficiency in the entire industry.

In addition, Schweitzer asserts that the Goldberg-Greenberg paper, which examines competition among for-profit insurers, and the Enthoven paper, which examines competition between health maintenance organizations and the fee-for-service sector, suffer from an absence of empirical evidence which would shed increased light on their plausibility.

Competition and regulation

To what extent might the policy alternatives of competition and regulation in the health care sector complement or conflict with each other in achieving quality care at reasonable cost?

Economists have a predisposition toward competition; yet, if enough competitive imperfections exist in the market, regulation can conceivably be a preferable second-best alternative.

Clark Havighurst, professor and director, Program on Legal Issues in Health Care, Duke University, espouses the view that more competition and less restrictive regulation is the prescription for controlling health care costs and delivering the health care mix desired by consumers. He contends that the laws which exempt health care premiums paid by employers from taxation act as an incentive for employers to provide more health care benefits than are desired by consumers.

Furthermore, Havighurst advocates strict enforcement of antitrust laws by the FTC to discourage boycotts by medical societies and physicians of those insurance companies monitoring physician procedures. According to Havighurst, one of the most important endeavors that the antitrust authorities can undertake is to strengthen the market mechanism that enables the for-profit insurers to control costs.

In contrast to this relatively sanguine view of the role of competition in the health sector, Stuart Altman, professor and dean, Florence Heller School, Brandeis University, and

Injecting doses of competition in only sections of the complex health care industry might not lead to more efficiency in the entire industry. Stuart Schweitzer.

Existing incentives and laws make a return to a competitive market in health impossible; hence, public regulations must be the inevitable "second best" alternative. Stuart Altman and Sanford Weiner.

The medical profession is a monopoly in the medical marketplace and prevents a free play of competitive forces. The antitrust laws should be applied to this monopoly. Richard Shoemaker.

The answer to quality care at lowest possible cost lies in a large-scale cooperative public-private effort—not necessarily in competition or regulation. Anne Somers.

Sanford Weiner, visiting researcher, Graduate School of Public Policy at the University of California, Berkeley, embrace a more skeptical approach. They claim that existing incentives and laws make a return to a competitive market in health impossible; hence, public regulations must be the inevitable "second best" alternative.

But the authors claim that regulation controlling output rather than encouraging changes in physician and hospital incentives will not be fruitful. The most important way that incentives can be changed is with an explicit organizational strategy that concentrates on behavior within the hospitals.

The similarities of 17th Century guilds and the present-day licensure and restrictive practices of the medical profession are explored by Lee Benham, professor of economics, Washington University. Benham believes that the guild philosophy is "still accepted in our attitude toward the role of competition, production and dissemination of information, and consumer choice." Benham feels there is little hope in changing the effects of the guild system; rather, he believes that the benefits of the system will go to those able to muster the most political support.

The comments in the session on competition and regulation are as varied as the institutions represented by the participants. John Pisarkiewicz, Jr., a former member of the Federal Trade Commission staff, strongly endorses Havighurst's call for vigorous competition in this industry. But he adds a cautionary note when he says that the theoretical underpinnings of a free market for health care may be difficult to achieve in practice.

Jesse Steinfeld, dean of the School of Medicine of the Medical College of Virginia, Virginia Commonwealth University, spoke for many of the conference participants when he said that if our goal is improved health, emphasis should be on health education, exercise, avoidance of tobacco, and other preventive techniques.

In addressing the issue of competition, Steinfeld claimed that competition exists in a form not considered by others at the conference. There is, for instance, competition among students to be admitted to professional schools and competition among researchers to discover the causes of various diseases. Competition as an option of the Federal Government should only be pursued as part of an overall national health policy.

Richard Shoemaker of the AFL-CIO said there is no "semblance of a market at all in the health industry." For example, he says, the medical profession is a monopoly in the medical marketplace and prevents a free play of competitive forces.

Shoemaker believes that antitrust laws should be applied to this monopoly—one of the most important endeavors, in his opinion, that the FTC could undertake.

Harold Cohen, director of Maryland's Health Services Cost Review Commission, agrees with the Altman-Weiner paper that the effectiveness of regulation depends on changing the incentives for hospitals, physicians and—Cohen adds—local regulators. Cohen concludes by suggesting that the Altman and Weiner case for regulation as a "second best" alternative is not made. In fact, he says the potential for physician dominance of regulation may make it the case of the "first worst."

Although endorsing competition as the most desirable method of allocating resources, Anne Somers, professor of the Department of Community Medicine at Rutgers Medical School, suggests two characteristics of the health care industry which might make this industry respond differently from other industries to doses of competition.

First, for most of the medical care sector, there is no consumer sovereignty. Second, the Government is "inextricably involved in virtually every aspect of the decisionmaking." Like Steinfeld, Somers believes the answer to quality care at the lowest possible cost lies in a large-scale cooperative public-private effort—not necessarily in competition or regulation. The important goal for the United States is universal access to health care. ■

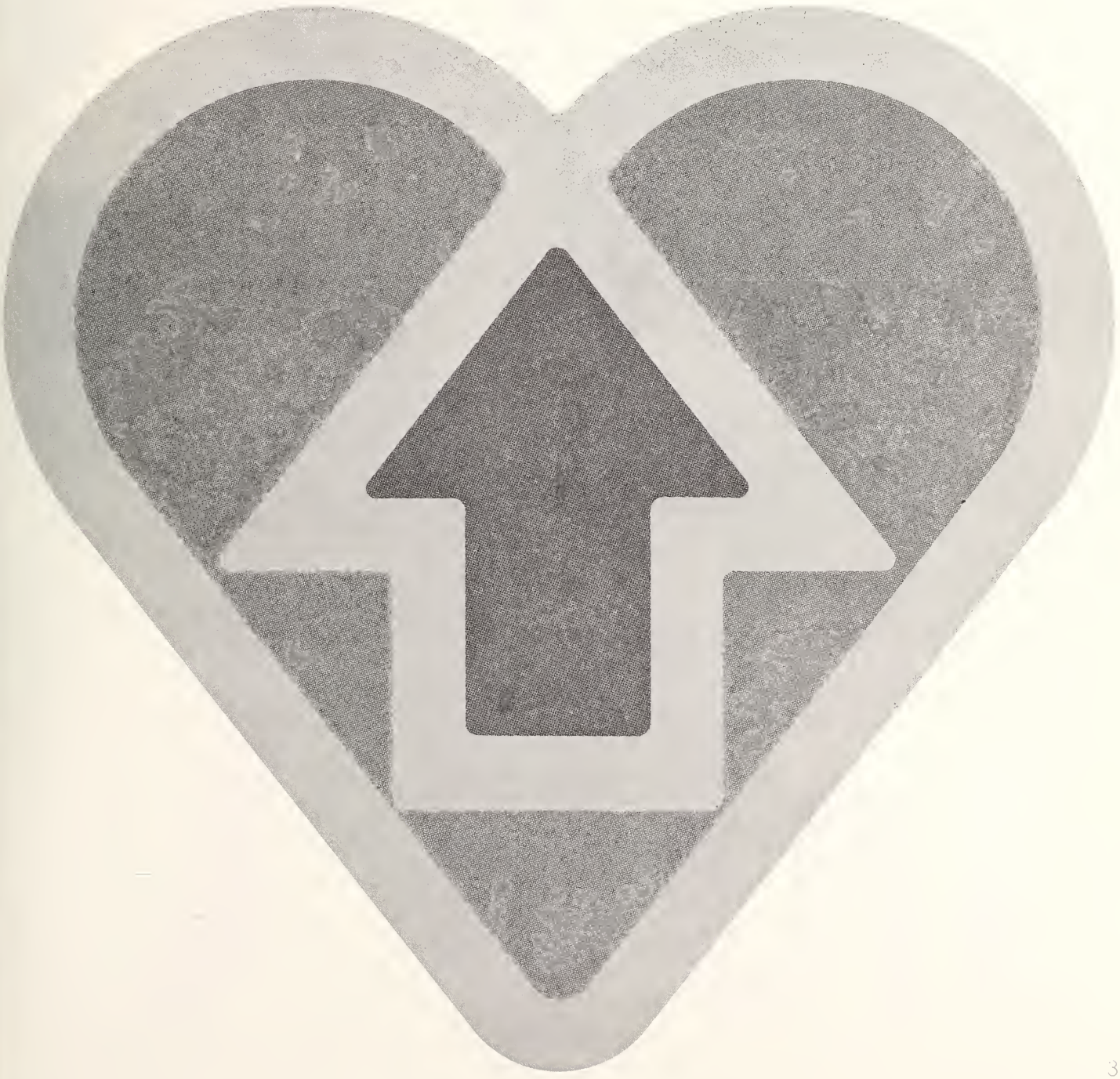
Don't Let The Silent Killer Silence You.

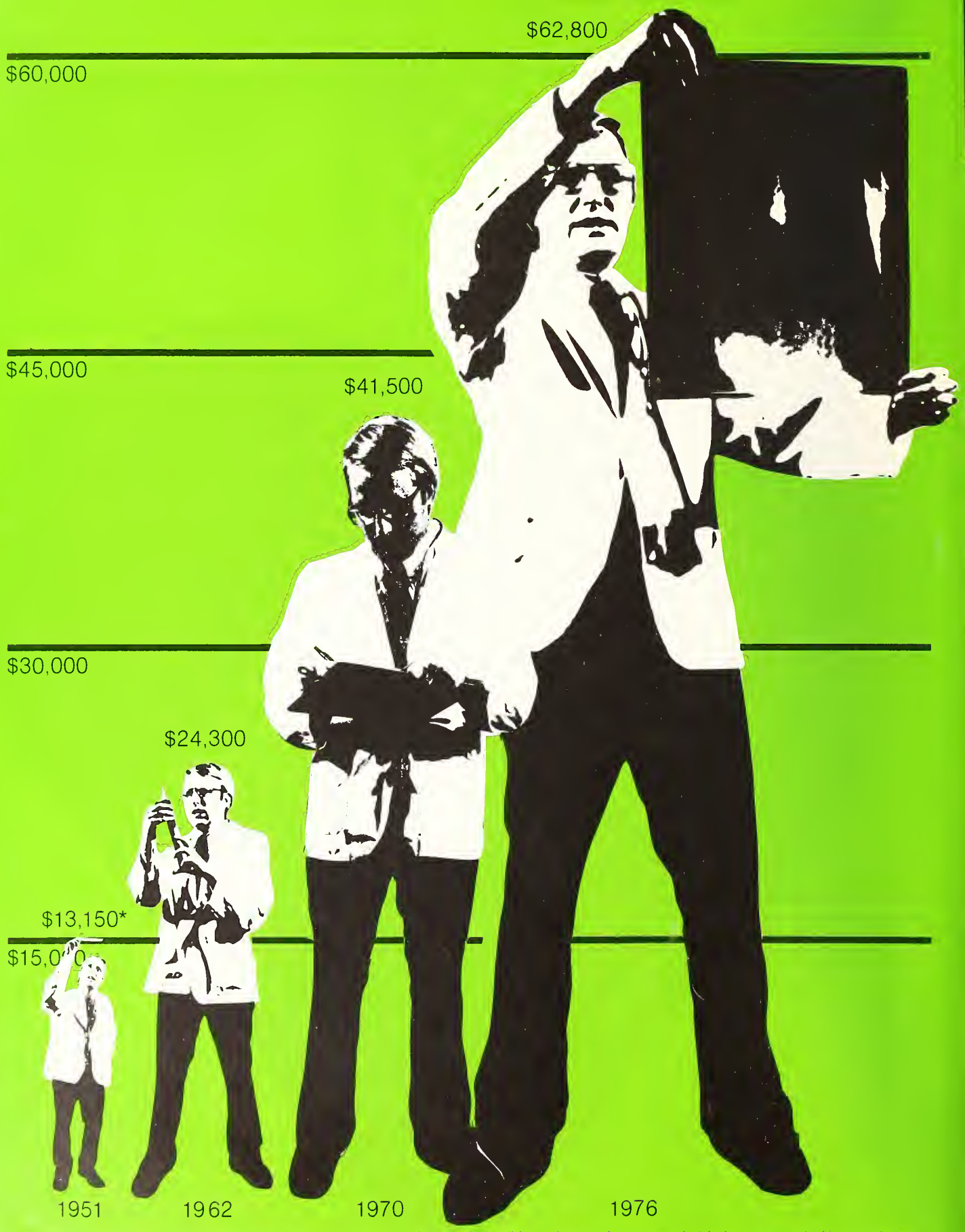
It's called the silent killer because it usually has no symptoms. You might not even know you have it. But high blood pressure can lead to stroke, heart failure, and kidney disease.

There isn't any cure for high blood pressure. Not yet, anyway. But it can nearly always be controlled, and if you have it, you can live a normal, healthy life.

Get a blood pressure check for yourself and every member of your family. Even the kids. If your blood pressure is high, see a doctor—and follow his advice.

Don't let the silent killer silence you.





*Median net incomes of office-based physicians from practice, after tax-deductible professional expenses, but before payment of income taxes.
Source, *Medical Economics Continuing Survey*

An Analysis of the High Cost of Physician Care.

by Ann Slayton

This article is based on, A Study of Physicians' Fees, *a staff report of the Council on Wage and Price Stability written by Zachary Y. Dyckman.*

The spiraling cost of physician care over the past three decades is a result of several factors, the most significant of which is inflated physicians' fees.

A Study of Physicians' Fees shows that between 1950 and 1977 physicians' fees rose 43 percent faster than the prices of non-medical goods and services.

During the 1950s and early 1960s physician fee inflation could be traced in large part to anti-competitive practices of organized medicine. Through control of the accreditation process, the American Medical Association restricted the growth of medical schools during the 1940s and 1950s, thus reducing the number of trained physicians. Partly because of these restrictions, the ratio of physicians to the general population was lower in 1960 than it was in 1950.

As demand for medical services increased and the per capita supply of physicians declined, physicians' fees and their incomes climbed. Between 1950 and 1965, physicians' fees rose 60 percent while non-medical prices rose only 30 percent.

Of course, all medical services have been a major source of inflation pressure in our economy. Through sharply rising medical care costs, health care outlays have taken a steadily greater share of the Gross National Product. In 1950 health care outlays represented 4.5 percent of the GNP. Today they total 9.3 percent.

Fee inflation is further aggravated by several factors which do not show up on the Consumer Price Index. For example, before 1950 charity care and discounts for patients with limited incomes were prevalent, especially for high-cost care such as surgery. But as more people acquired health insurance and as plans became more comprehensive, the practice of fee discounting diminished. Because the CPI tended to measure changes in the customary fee rather than in the average or "transaction" fee, an understatement occurred in the measurement of physician fees. This bias means that physicians' fees increased 20 percent more rapidly per year between 1950 and 1976 than the increase reflected in the CPI data.

The principal causes of fee inflation have changed dramatically since 1965. Since that time the per capita supply of physicians has increased substantially and some anticompetitive practices of organized medicine have declined.

Two primary sources of fee inflation are the growth in coverage of both public and private health insurance and changes in methods of insurer payment for physician services. While more extensive health insurance coverage has enabled more people to receive medical care, it has exempted physicians fees from the usual restraining market forces that operate on most other consumer products and services.

Between 1950 and 1960 the number of persons covered by surgical insurance doubled from 54 million to 112 million. The number covered for non-surgical services almost quadrupled from 22 million to 83 million. Today, between 160 and 170 million people have private health insurance covering physicians' services.

During the 1960s and early 1970s a change in the method of paying for physicians' services significantly reduced consumer incentives to resist their higher costs. Instead of paying fixed dollar amounts according to a schedule of fees, many insurers started paying a "usual, customary and reasonable" fee. This method typically reimburses the physician for 80 to 100 percent of his fee as long as

---

Ann Slayton is a staff editor in HCFA's Office of Public Affairs.

A Study of Physicians' Fees *(Ordering No. 041-001-00163-8) is available for $3.25 from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.*

the fee is not among the highest 10 percent of fees for that service in his area. In effect, then, physicians determine their own fees in an environment relatively void of consumer pressure to restrain fees and this sets off spiraling fee inflation.

This is especially true in those specialties for which income from third-party payments is greatest. In surgery, radiology, anesthesiology, and obstetrics/gynecology, sometimes 80 percent of physician revenues come from third-party payors. This is not the case with general practice, pediatrics, and psychiatry, where the consumer typically pays a greater share of the bill. Studies show that specialists whose primary source of income is from third-party payors have substantially higher earnings than other physicians.

As a result of fee inflation, of course, all physicians' incomes have grown rapidly, a trend which has been developing for many years. In 1939 physicians earned less than twice as much as those of a broad group of professional and technical workers. But by 1975, physicians' earnings were four times as great. In 1976 the median income of self-employed physicians was $63,000, a figure which is higher and has risen faster than that of any other major occupational group for which historical data is available.

But $63,000 is a median figure. The highest earnings among broad specialty groups go to pathologists and radiologists. One study put their average earnings at about $100,000 in 1975. And those pathologists and radiologists whose incomes are derived from hospital contracts earned $138,000 and $122,000, respectively, in 1975.

Many of these income variations seem to be little related to supply. For example, though there is a greater relative supply of surgeons than primary care physicians, surgeons earn considerably more than internists, general practitioners, and pediatricians.

Needless to say, it is the consumer—the willing consumer—who, directly or indirectly, pays the physician's wage. Consumer outlays for physician services have risen even faster than fees, increasing from $2.7 billion in 1950 to about $35 billion in 1978. Sixty percent of the increase is the result of higher fees, while the rest is attributed to population growth, increased quantity of such services as diagnostic tests, and more frequent visits to the physician.

The increasing supply of physicians has oddly enough also been linked to fee inflation, providing another example of malfunctioning competitive market factors. The supply of physicians has increased from 158 per 100,000 persons in 1970 to 177 in 1975. With continuing immigration of foreign-trained physicians and expanding medical school enrollment, HEW estimates that by 1985 there will be 222 physicians per 100,000 persons.

There is some evidence, though, that many new physicians are practicing not in areas where physicians are in short supply but where there is already an oversupply. It has been suggested that, given extensive insurance coverage and lack of consumer resistance to high care costs, physicians practicing in these oversupplied areas can, to a certain extent, induce demand for their services and raise their fees. Thus, higher costs of hospital and physician care may be generated with little improvement in the overall health care of the people living in those areas.

Looking closely at variations in surgical fees throughout the country, the study found that after adjusting for differences in cost-of-living and other factors, surgical fees are highest in the West, in very large cities, and in areas experiencing rapid population growth. Average surgical fees in some large cities are, for example, more than twice as high as those in smaller communities. And, again, it does not appear that fees are lowest where the surgeon supply is greatest. In fact, fees are found to be higher where the relative physician supply is greater.

The rising expenses of physicians are often cited as a reason for escalating fees. Between 1971 and 1976 physician expenses rose more rapidly than all consumer prices, but at a slightly slower rate than physicians' fees. The largest increase in expenses during 1975 and 1976 was for malpractice insurance, which, according to one source, rose 84 percent in 1975 and 42 percent in 1976. However, because malpractice insurance was not a major cost for physicians before 1975, these steep increases cannot explain the large differences between inflation in physicians' fees and overall prices during 1975 and 1976.

With higher incomes and extensive insurance coverage, the American people have demonstrated their willingness to pay handsomely for dramatically improved medical care. Sophisticated, expensive treatments are being used today for illnesses and conditions which, even 10 years ago were thought to be untreatable. Much of this sophisticated care is given by specialists who composed less than 40 percent of all physicians in 1950, but who in 1976 accounted for 85 percent of all physicians. The higher fees that specialists charge for the same services provided by general practitioners contribute to fee inflation.

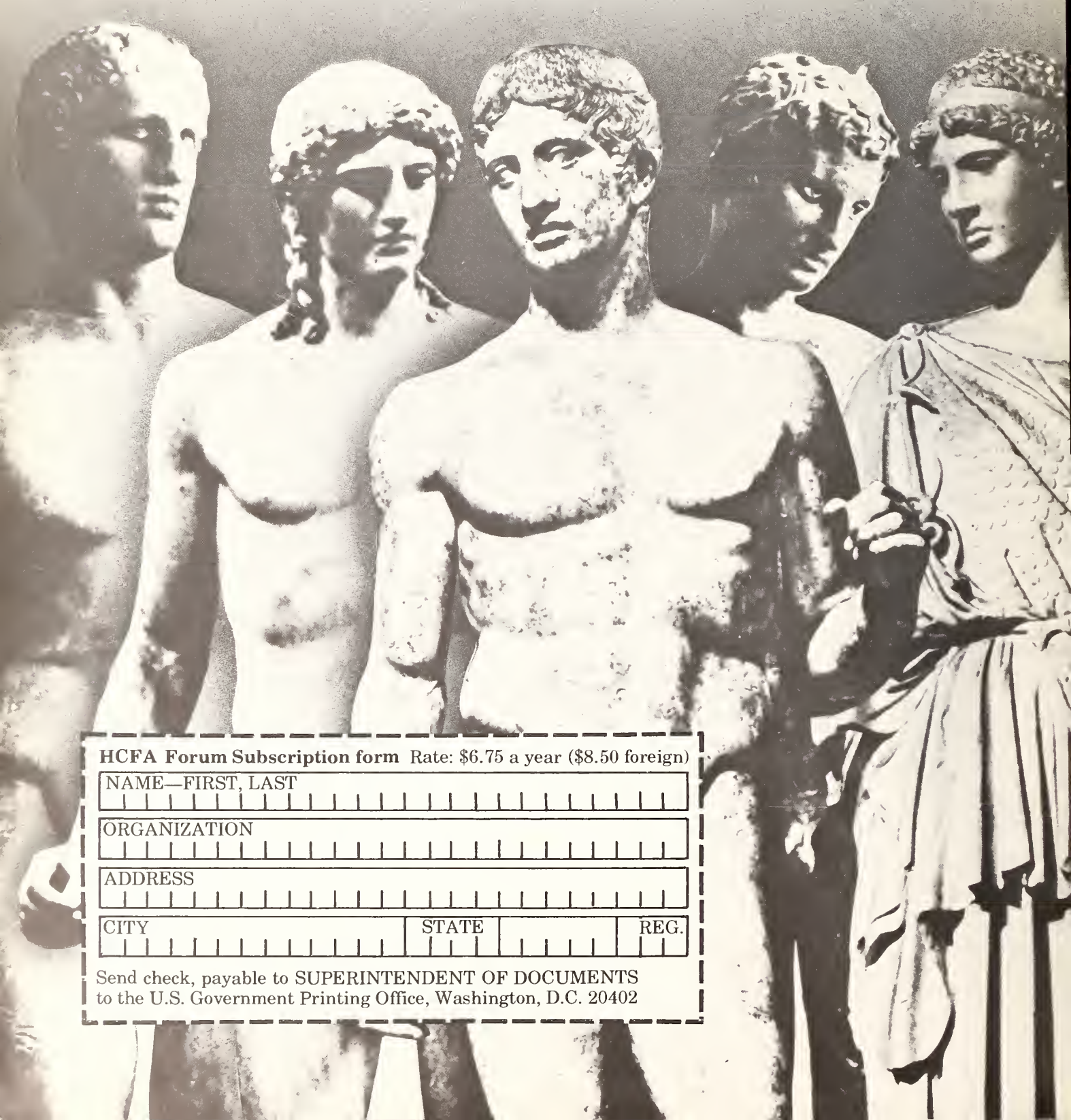
A Study of Physicians' Fees concluded that many of the forces which have caused fee inflation continue to exist, including: few competitive pressures to restrain fee increases, extensive health insurance coverage and reimbursement practices which allow the physician to set fees. In terms of consumer outlays, the situation is similar: extensive insurance coverage removes consumer resistance to using high cost services; increased use of diagnostic tests which physicians believe will ward off malpractice suits; and an increased number of physicians able to induce demand for costly services. All these factors may portend even more rapid rates of growth in consumer outlays for medical services than are currently being experienced. ■

Distribution of Medicaid Dollars by Type of Service for Fiscal 1977.

DEPARTMENT OF
HEALTH, EDUCATION,
AND WELFARE
Washington, D.C. 20201

Official Business

Postage and Fees Paid
U.S. DEPARTMENT OF H.E.W.
HEW-392
CONTROLLED CIRCULATION



HCFA Forum Subscription form Rate: $6.75 a year ($8.50 foreign)

NAME—FIRST, LAST

ORGANIZATION

ADDRESS

CITY | STATE | | REG.

Send check, payable to SUPERINTENDENT OF DOCUMENTS
to the U.S. Government Printing Office, Washington, D.C. 20402